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SOME REMARKS ON GROUPOUS PNEUMONIA.*

By HARDEE JOHNSTON, M.D.

BIRMINGHAM, ALA.

This disease is as old as the history of medicine and has claimed for its victims the young, the adult and the aged since time was. Unique in the fact that under all the varying treatments of the different ages of medicine, it still seems relentless; and, treated with the deference of modern views or the aggressiveness of past days, pneumonia remains unaffected, still waging its successful war.

The pathology of this disease is so well known that I feel it would be a needless repetition for me to attempt to restate it. I am only desirous of calling your attention to the fact that it was at first supposed to be a disease of the lung alone—in other words, not a general systemic affection. The latter and correct idea was first advanced about thirty-five years ago by Loomis in our country and Jeurgensen in Europe. They both held that in spite of the striking symptoms and disturbances in the lung, that correctly understood pneumonia was a systemic infection accompanied by the congested and consolidated lung area.

They must have arrived at this conclusion through observing the clinical facts that a large consolidated area of lung tissue does not necessarily accompany a virulent type of the disease, and that a small area of consolidation may be associated with extreme prostration and death. These clinical facts, together with the knowledge that the

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lung may show signs of consolidation long after all other symptoms of pneumonia had disappeared, was sufficient evidence to point out the true pathological condition. I mention this particularly because it serves to illustrate the value of clinical and physical signs. We are prone now-a-days to belittle any evidence so obtained and to question the ability of any one to form a correct concept of the state of things through such evidence. We believe no opinion should be risked until the microscope has been called into service, or perhaps a post mortem has been held. This may be all right and is only the proper scientific caution we should display. But I feel sure that it is a serious scientific mistake not to seek after every available clinical fact and strive for a scientific interpretation of the same.

Pneumonia is usually stated to be a disease common to all climates and all countries. More correctly put, it is a disease common to the temperate zone, but almost unknown in the arctic and tropic regions. The period of greatest frequency occurs during the autumn, winter and spring months. No age is exempt, though it is a disease of adult life, and men are more often attacked than women.

It was once believed that sudden or prolonged chilling of the body was the exciting cause in this disease, but we now know that the pneumococcus pneumoniae is responsible. There is abundant evidence, however, both direct and indirect, which goes to prove the association of pneumonia with a history of a previous chilling. In what way can we explain this connection?

Extreme cold produces these physiological phenomena: first, a temporary congestion of the internal organs; second, a decrease in heart power; third, a lowering of the body temperature; and fourth, shallowed and slowed respiration.

We know that the pneumococcus is not infrequently found in the mouth, throat and bronchi of a normally healthy person, and as far as any evidence to the contrary is concerned, they may be found in the lung itself. With this chilling process we may have these pneumococci deserting their frequented places in the throat and bronchi and following the congested tracts. From the anatomical structures we would naturally suppose the lower lobes of the lung would furnish the seats of greatest congestion. The small capillaries might rupture and the germs be liberated around air cells, under favorable conditions for their propagation, and systemic infection result. This I mention as a possible hypothesis which might serve to explain the frequent association of pneumonia with a history of a previous chilling, and it may also serve to explain the frequency with which the lower lobes of the lungs are attacked.

The variable climate is the climate particularly affected by pneu-

monia, not because the germ flourishes under change, but only because a sudden chilling and congestion is so much more easily brought about. The months showing the greatest, most frequent and sudden variations in temperature are the months marked by the short illness and sudden respite common to this disease.

Statistics prove that pneumonia has been steadily increasing within the last decade throughout the large cities of the East—New York for instance. Why is this? Are city dwellers becoming more susceptible to this germ? Is the crowding together of so many people responsible? I believe not. Can we not explain this increase in the same way we account for the greater frequency of pneumonia during certain months of the year? It is the rule now-a-days to have steam heated houses. This generally means a continual dry over-heating, and this means that city dwellers are being constantly subjected to possible chillings with the consequent temporary congestion.

As to the symptoms of pneumonia: There are comparatively few individuals who, at the mention of this disease, do not mentally call up a picture of the bedside of some friend or relative who has felt the grip of this enemy. Who is not familiar with the chill, sudden onset, fever, cough and painful respiration? and so I shall spare you any such tiresome repetition.

The treatment has been everything and nothing, and the generally expressed opinion now is that nothing is preferable to everything. In this I heartily concur, if by "everything" is inferred just anything; but only so far do I agree.

Having no definite specific to rely upon, no curative agent which comes labeled "for pneumonia," shall we join the fashionable and supposedly extremely scientific, and decry all treatment?

Unquestionably such a procedure in our dilemma would prove the easiest, and we may be able to satisfy conscience and the friends of our patients. But let us hope that we will reserve such an attitude for learned discussion upon this subject rather than in a practical application upon the unfortunate.

Having no recognized specific for pneumonia—that is, no curative agent that, independent of conditions or things, directs its force directly against the germ or toxin eliminated by this germ, have we no other scientific indications for treatment?

There are two primal indications for treatment in any disease, two primal factors always to be considered. The first is that usually known as specific treatment—that is medicaments which supposedly have a direct influence upon the life or activity of the germ which is responsible for the individual disease. Second, medicaments, of whatever nature or kind, that have a direct influence upon the morbid conditions of the body brought about by the action of these germs.

The history of medicine for many centuries confined itself and had to do almost exclusively with this last phase. It is only comparatively recently that specific treatment has been practiced or known ;and because of its comparative newness it has absorbed our attention and filled our mental vision to the exclusion of any other treatment. Frequently the life and death of a germ or cell has come to be of more scientific importance and interest than the life and death of the individual. It seems to me that our sense of proportion, our appreciation of the value of things, has fallen sadly in error, and we have shown precious little common sense. Take the attitude of the profession in this particular disease, pneumonia, and in a moment you see the absurdity of it. Here we have a disease increasing in frequency every year, a disease that furnishes the climax to many useful lives, and yet our interest goes little further than a diagnosis, and treatment is dismissed because of the lack of a specific. We believe that nature or the physical forces of the body will successfully combat the foe in some instances, in others the body must succumb. Does it occur to us that it may be possible through a proper alleviation of those morbid conditions which go to exhaust vitality, that many lives that we are accustomed to place amongst the condemned may be saved? And through efforts not against the germ, but against the morbidity produced, we may successfully treat almost all uncomplicated cases.

In some cases of pneumonia the resistive power of the body are so great, or the degree of infection so slight, till the crisis is past and no indications for any medicaments has arisen. But this, unfortunately, is not the rule. So it is well to consider more particularly the morbid conditions usually observed in this disease, that tend to exhaust vitality and lessen the resistive forces.

The fever accompanying pneumonia is usually high and continued, and I am satisfied has a direct weakening effect upon the heart, besides in some sort being responsible for many nervous symptoms, which in themselves tend to exhaust the vitality of our patients.

This pyrexia, then, is a symptom which calls for our attention. How shall we meet it? Shall we give a coal tar product in sufficient dosage to reduce the temperature? No, for one of the reasons necessitating the reduction contra-indicates the use of any such antipyretic, that is, the direct weakening effect upon an already burdened heart.

And this brings me to the primal object of this paper.

We have an agent that has been employed for this purpose, intermittently, throughout the last twenty-five or thirty years—one deserving a better reputation than it now enjoys, namely, quinine.

The first reference I have been able to find in respect to the use of quinine in pneumonia is by Juergensen, who employed it with

marked success. Loomis also recommends it. Neither of these two observers were able to discover any deleterious effects from the use of this drug, and they not only obtained a direct effect upon the temperature, but, further, their pneumonia patients began to get well with very much greater frequency.

Is it possible that quinine is in some sort a partial specific in this disease? Does it have a direct inhibitive action upon the pneumococcus itself? This is my belief, and for the following reasons:

First, there is no doubt that quinine will affect a reduction of the temperature in pneumonia, and yet we know that this drug is no true antipyretic. It has no effect upon the temperature in health. It will reduce the temperature in malaria, and accomplishes this through its action upon the plasmodium. It will reduce the temperature of septic infection, and must do so through specific action upon the streptococcus. And so, reduction following its employment in pneumonia, it may reasonably follow that this reduction results from its specific action. The specific action of quinine being granted in pneumonia, the question arises, why then, after the reduction of temperature should there be any after rise of temperature, or any further symptoms of the disease? If a moderate dose of this drug will reduce the temperature and alleviate the symptoms, why not produce a complete cure by the exhibition of a large dose? This very thing has been tried, and what was the result? The patient's temperature dropped to normal and to all appearances he seemed a well man. This condition lasted from about 12 to 24 hours, to be superceded by high fever and more aggravated symptoms altogether than at any previous time of his illness.

This result would seem to be rather unfavorable to any belief in the supposed specific action of quinine. But I believe there is an explanation for the subsequent rise of temperature and general collapse, that is not opposed to the belief in quinine as a partial specific in pneumonia.

One of the most marked and curious actions of quinine is found in its effect upon the white blood corpuscles. We know that they lose their power of migrating from the blood vessels, that they are decreased as to number, and, in all probability, are rendered temporarily functionless. They must then lose their aggressiveness toward germs.

We have by the exhibition of this large dose of quinine, killed the pneumococci which are responsible for the systemic infection and disturbances, and we have at the same time rendered passive the white blood corpuscles. The foci for a new infection exists in the pneumonic lung, and from thence there comes a new invasion of the enemy, which finds the system all unprepared, for no reliance can now

be put in the sluggish white blood corpuscles, and so the condition of high fever and great systemic infection is the natural one to be expected.

It might be argued that in intermittent malarial fever, if the above theory is true, we should expect a similar rise in temperature and a more severe chill after a large dose of quinine had been given. But there is little true similarity. For, to commence with, we know that quinine in very weak solution is extremely deadly to the plasmodium, and, further, there is no focus for a second infection existing within the body, and still further, a period of 36 to 48 hours must elapse before the plasmodia who may have escaped the toxic effect of the quinine begin to give rise to symptoms. This period may be sufficiently long to allow the white blood corpuscles themselves to recover and again become factors of resistance.

If there is any truth in the above theory, it follows that one fact must not be lost sight of in the administration of quinine in pneumonia, and that is, the danger of a reinfection from the consolidated lung area, which we cannot reach, particularly dangerous because we have temporarily put out of business the white blood corpuscles. To counteract this danger, it becomes necessary that the quinine be given continually throughout the attack.

My own experience in the use of quinine in pneumonia extends over a period of nine years, and though the number of cases treated may be insignificant the uniform result may count for something.

The first case happened to prove my only unfortunate. The patient, a man about 55 or 60 years old, and bed-ridden from inflammatory rheumatism. He had a grave organic heart lesion. I thought that he would die early in the attack, but to my surprise he out lived the pneumonia, to die about four or five days after crisis from heart failure.

During this period I have had two cases of double pneumonia, two cases complicated by heart lesion, and four cases in people ranging from 55 to 70 years of age. I mention this to show that they have not all been of a type that were sure to get well if let alone. The number of cases I believe to be between fifty and sixty. I have prescribed quinine in from three to five grain doses repeated every two hours until twelve to twenty grains are taken, the amount given varying with the mildness or severity of the symptoms. Not infrequently I have combined a minimum dose of acetanilid with the quinine.

This quinine I have kept up steadily throughout the attack, irrespective of anything else that may be given, and I have yet to see the pneumonic patient upon whom it has had any untoward action or produced other than the happiest results.

I have given quinine consistently in pneumonia believing in its specific action; but I have supplemented this with purely symptomatic treatment whenever I believed necessary.

As to the symptomatic treatment in this disease, little can be said; not because the subject is in any way unimportant, but because of the varying condition and patients. It would be just as reasonable for a tailor to attempt to make one garment fit all of his customers as for a doctor to treat symptomatically all of his pneumonias alike. In both instances alterations are necessary.

As in any disease, do not give a medicine unless you believe the indications call for it, and do not hesitate to give any medicine if you believe it indicated.

THE PRESENT STATUS OF THE SURGERY OF THE STOMACH.*

By WILLIAM D. HAGGARD, M.D.

NASHVILLE, TENN.

The triumphs which surgery has achieved over certain diseases of the stomach comprise one of the most useful and gratifying experiences which has crowned the efforts of our profession in the last decade.

It has demonstrated anew that, as the hand-maiden of medicine, surgery is ever widening the limits of its helpfulness and adding new lustre to its already brilliant achievements.

The modern surgery of the stomach is not more than four or five years old and in its more perfected aspect it is only half that old. Its results judged by statistics before that time are not comparable to its present accomplishments and the oft-repeated reference to its "frightful mortality" should give place to the recognition of its present surprisingly low death rate.

Improved technique, low mortality and satisfactory results will inevitably do away with the empirical treatment of occult intractable stomach troubles. Operating room demonstration of pathology in vivo is impressing the easy mechanical relief of these lesions.

A closer intimacy with living pathology will instil the lesson which we have learned so well in other portions of the body, where the golden opportunity is no longer permitted to slip away.

The typical indication for operative interference is obstruction of the pylorus from an open or cicatrized ulcer causing dilatation of

*Abstract of the Address on Surgery before the Mississippi Valley Medical Association at Indianapolis, October 16, 17, 18, 1905.

the stomach with stasis of food. The short circuiting operation of gastro-enteric anastomosis finds its ideal indication here, and has given most beneficent results.

The complications of ulcer requiring operation are (1) perforation, (2) hematemesis of chronic ulcer. Hemorrhage from an acute ulcer is rarely fatal and is usually amenable to dietetic treatment.

Operation is advised in repeated acute hemorrhage or in constantly recurring small hemorrhage.

Other indications are found in the following groups of cases:

(3) Obscure and persistent stomach symptoms with a long history of dyspepsia culminating in hemorrhage after it has been controlled by medical means and the patient put in the proper condition for operation (Cabot).

(4) Cases of chronic intractable dyspepsia even without dilation which fail to yield to proper medical treatment and are not due to general visceral ptosis.

Waterhouse says that unless definite improvement manifests itself after three months of medical treatment of chronic ulcer, or if all serious symptoms have not disappeared after six months' treatment the case should be considered one for surgical, rather than for continued medical aid.

Other authors specify operation in cases in which "three" systematic ulcer cures have not cured, and a prominent surgeon facetiously remarks in reference to these cases that operation is contra-indicated unless the patient has had as many as nine permanent and complete cures.

The greatest desideratum in gastric surgery is operation in the early stages of cancer and hence in enumerating the indications it may be summarized in the phrase (5) "upon suspicion of cancer." A synopsis of the other stomach conditions for which operation is recommended is as follows:

- (6) Disabling perigastric adhesions.
- (7) Congenital stenosis of pylorus.
- (8) Fistula between stomach or pylorus and adjoining organs or even with the surface of the body.
- (9) Hour-glass stomach.
- (10) Congenital hour-glass stomach (Brooks).
- (11) Volvulus.
- (12) Tetany due to obstruction and dilation (Cunningham).
- (13) Spasm of pylorus (Reichmann's disease).
- (14) Sub-phrenic abscess.
- (15) Perforating wounds of stomach.
- (16) Non-perforating trauma (Monprofit).
- (17) Cirrhosis (Sheldon)

(18) Foreign bodies.

Riegel estimates the mortality of gastric ulcer at 8 to 10 per cent; Lebert at 10 per cent; Welch at 15 per cent; Von Leube 25 per cent, Bebove and Raymond 50 per cent.

As bearing upon permanence of cure, Russell studied 89 cases of gastric ulcer, covering a period of 7 1-3 years. 44.7 per cent. were found to be suffering from stomach symptoms at the last report; 14.9 per cent. were having repeated and definite attacks with intervals of immunity, and 29.8 per cent. suffered almost continuous pain.

Another group of 6 per cent. could not as yet be classed with the uncured 44.7 per cent. Contrast this very lame showing to the graphic description and beautiful results of Moynihan:

"Indeed I do not know any operation in surgery which is more successful or which is attended by better or more striking results than gastro-enterostomy for chronic ulcer of the stomach. A patient thin, shrunk, cadaverous, and gloomy in aspect, who has been chiefly occupied in trying to avoid acute attacks of indigestion or vomiting, whose whole attention is concentrated on his stomach, who considers every article of diet carefully before he takes it and by degrees abandons first this dish and then the other until he is finally reduced to fluids alone, who indeed has never conceived that any other question than that of his own health could seriously interest him—a patient, to say the truth, whose whole existence has been ordered and regulated by his stomach, finds after a gastro-enterostomy has been performed for his chronic ulcer that he can eat what he likes in any quantity he likes, that he rapidly puts on weight and that his general sense of well-being is almost beyond belief. From being a misanthrope he becomes an enthusiast and an optimist. I have often wondered with a certain amusement what would have been the result of a timely gastro-enterostomy upon Thomas Carlyle. He might have taken to the writing of comedies and threatened the throne of Congreve, and his portrait twelve months later viewed side by side with that done by Whistler would have proved an eloquent advertisement for his surgeon."

The first four inches of the duodenum is embryonically, physiologically and surgically a part of the stomach. Duodenal ulcer therefore does not differ etiologically from it. It is most frequent in men and in the fifth decade of life. It occurs often in the professional classes who live too well and develop hyperchlorhydria. It is characterized by pain an hour before meals or in the early morning hours and relieved by food. Malena is frequent. It is relatively very much more frequent than has been supposed. In a period of 2 1-2 years Mayos found out of 231 cases of gastric and duodenal ulcer the duodenum to

be involved 74 times, or 32 per cent. In 42 operations for chronic duodenal ulcer he had only a single death. It is exceedingly prone to perforate, and takes place usually in men in prime of life with perhaps little or no stomach symptoms. Murphy says perforating duodenal ulcer is practically impossible to diagnose accurately without exploratory laparotomy. As a most remarkable series of cases I will quote Turner, who saved eight out of nine cases at St. George's Hospital. They were operated 4, 5 1-2, 10, 12, 17, 24 and 48 hours respectively after onset of symptoms.

The only unsuccessful case was operated on the third day when practically moribund.

D'Arcy Powers gives the following forceful description of a typical example of chronic duodenal ulcer. "He tells you that he is a martyr to indigestion and that for months past he has suffered atrocious pain in his stomach which is relieved by vomiting; he has dieted himself in every possible manner; he has made all kinds of applications to his abdomen; he has visited all sorts of water places and he has gone in vain from one physician to another seeking a cure. Examination shows him to be a mere bag of bones, badly constipated, cold extremities and a listless, dejected aspect. His abdomen is loose, the subcutaneous veins dilated, and a visible peristalsis from left to right in the epigastric region. Percussion tells you that the stomach is greatly dilated and it is not very unusual to feel a tumor in the neighborhood of the pylorus or gall-bladder, and you question the patient a little more closely. He is sure that he has been suffering for years—for so long, in fact, that he hardly recollects the beginning of his troubles. A few well directed inquiries may elicit that twenty-five or thirty years ago, when he was a young man, he once or twice brought up a large quantity of blood without serious pain or discomfort, or that he had an illness which no one seemed to know much about. He was treated for gall-stones or appendicitis, or simply for 'liver.' The attack was painful and kept him in bed, but the exact details have passed from his mind and for some years he was as healthy a man as ever.

"This is a case of duodenal obstruction resulting from cicatrization of an old ulcer, the irritation of which has caused inflammatory thickening in the surrounding parts. How many patients have been allowed to die of such a condition in the belief that they had malignant disease of the stomach no one can tell. But for such patients a gastro-jejunostomy holds out the prospect of a speedy and perfect cure."

It is in duodenal or pyloric obstruction that gastro-enterostomy finds its most exquisite indication and attains its highest efficiency.

The essentials of the present perfected posterior operation are (1) the selection of the very bottom of the stomach (Mayo); (2) the obliquity of the opening from above down and from left to right (Moynihan); (3) the utilization of the jejunum as it drops straight down and at a point where it normally lies in contact with the posterior wall of the stomach with only the meso-colon intervening (Petersen); (4) anastomosis effected with clamps and simple suturing with linen thread.

This technique has enabled Moynihan to report 173 operations for benign conditions with only two deaths. Mayo performed 307 operations by various methods with 19 deaths (6.1-2 per cent.). In the last 140 there were only four deaths (2.6-7 per cent.), and in the last 80 by practically this method there was only one death. Mayo for the last few months has been making the anastomotic opening obliquely from above down and from right to left instead of vice versa as in "Moynihan's oblique line."

Heretofore great consideration has been shown the line of peristalsis of the stomach, but Cannon and Blake have shown that no matter where the opening is made the stomach by its rhythmic, milking-like action makes the point of exit the lowest part of a spindle and ejects the food in jet-like movements.

All of our past trouble has been with the jejunal side of the anastomosis and not with the gastric. The right oblique opening is in more harmonious relation to the course of jejunum at that point than the left oblique.

I have employed this technique in three cases recently with most ideal results so far.

The most crying need in all medicine is some means for the early recognition of cancer of the stomach.

The early diagnosis of the other great scourge of mankind—tuberculosis—is satisfactory, but unfortunately there is as yet no radical cure for it.

If it were possible to diagnose gastric cancer in its very incipency a very large number could be saved by operation. The anatomic and lymphatic conditions are very favorable for an ideally early operation.

Until the magic and immunizing therapy which will convert malignancy into benignancy is discovered, extirpation is our only resource.

One-third of all carcinomata are in the stomach. The average duration of life is nine months. Diagnosis by medical means is usually too late unless it is made by a strong surmise and confirmed by exploration incision. Laboratory methods are unavailing in the operable period, as no change has taken place in the secretions. Any obscure

digestive case, where pernicious anemia is excluded, and especially if HCL is absent, demands exploration. Riegel asserts that better results in gastric cancer will only come when the internist acquires the diagnostic courage necessary to enable him to act on that suspicion before it becomes a certainty. Persistent digestive cases should be watched carefully for a few days or weeks only. If there is progressive, but slow development of disordered function with pain or vomiting, impaired secretion, emaciation and especially tumor, the wisdom of prompt exploration should be frankly put before the patient.

Czreny's dictum that the presence of a tumor is too late for operation has been disproved by Kertes' experience.

If exploration proves the condition inoperable, the wound should be closed with buried non-absorbable sutures and the patient gotten up and out of the hospital at the end of a week. If obstruction is serious a quick gastro-enterostomy is relatively safe. Robson had only one death in 24 palliative operations. Relief from pain and vomiting is most grateful and life is often prolonged for many months and in a good many instances to a year or longer. The danger of an exploration is not *per se*, but in ill-advised and over zealous efforts to attempt interference in conditions that should be left severely alone.

The Mayos in 114 malignant cases had twenty-one deaths, or 18 per cent. There were 63 pylorectomies and partial gastrectomies with eight deaths, or 13 per cent. The worst cases had only a gastro-enterostomy and the severity caused the high mortality. In the last forty-one cases for malignant disease operated in the last 22 months the mortality was only 8 per cent.; 25 consecutive with 1 death, 4 per cent. As to ultimate results in 70 cases of resection four lived more than three years, three are still alive and without return, a number are well after two years, and majority lived over one year. Of the 16 operated more than three years ago, four are living, or 25 per cent.; one is alive and well after four years and ten months.

Of Kerte's 22 patients who survived the operation, 13 lived from one to five years; 9 were still living from one to five years.

The late lamented Mikulics, who did more than any contemporaneous European surgeon for the advancement of gastric surgery, obtained a permanent cure or immunity for over three years in 16 per cent., and sadly enough he at last fell a victim to the dread malady for whose alleviation he had done so much. He cheerfully assented to exploration at the hands of Eiselberg and when it was found inoperable he recovered and continued undauntedly at his work until the end. Than this there is no greater heroism.

Selected Articles.

EARACHE.

By ALBERT BARDES, M.D.

Attending Surgeon at the New Amsterdam Eye and Ear Hospital.

NEW YORK.

The recent observation of a number of fatal cases of acute otitis media, that at first were treated in a haphazard manner by the family physician, has led me to sound a note of warning in regard to earache, that this painful symptom may receive the full attention that its seriousness deserves. No pain is capable of producing greater suffering than a severe earache, even child-bearing is less painful, and no disease is more dangerous than that of which earache is the principal symptom.

Earache is regarded far too lightly by many physicians, and in many of the neglected cases, either the termination is fatal or the hearing becomes impaired, or a chronic running ear is developed. It is wrong to regard an earache simply as a painful symptom that usually passes off as soon as the drumhead bursts. Rightly considered, it is the sign of a dangerous infection that may impair and even destroy the sense of hearing, and may even cost the very life of the sufferer.

Even to this day, most mothers look upon an earache in a child as being one of the troubles that any child may get, like measles, scarlet fever, or chickenpox, and nothing is done to relieve the trouble save to drop some laudanum or warm sweet oil into the ear. Fortunately, a child does not suffer long, for the thin drum-head soon yields to the pressure of the inflammatory exudate and the fluid escapes from the ear. Not infrequently earache in an infant is not recognized as such. The suffering is usually ascribed to the teeth, and the error is not discovered until the ear begins to discharge.

In most instances the let-alone policy of treating infantile ear troubles is attended by no bad results, but in certain cases, through lack of attention, the condition becomes serious and speedy intervention is demanded to save the hearing and perhaps the life of the patient. In former years many mothers were told that their child would outgrow an ear trouble, and they were advised to let nature take its course. That such advice is harmful, and even dangerous, is apparent to every one who treats the ear.

When we stop to think that in civilized life one person in every three has some defect in hearing, and that most of these defects date from infancy, we begin to understand the importance of treating the ears of children at the outset of the trouble. The entire surface of the middle ear, if spread out, would not be larger than a silver quarter; enclosing a space the size of a dried pea, yet this small cavity is the most useful, and at the same time the most vulnerable one of its size in the entire body, because of its close proximity to the brain and to the internal ear.

For the production of an earache two things are essential: an inflamed middle ear and an exudate that presses upon the drumhead. Normally, the middle ear is an aseptic space and its mucous lining exerts a protective influence and guards against infection. As soon, however, as there is a breach in its surface it ceases to protect; on the contrary, it favors the development of pathogenic organisms. In almost every instance the middle ear becomes diseased through the passage of infectious matter from the nose, at a time when the condition in the middle ear is abnormal.

Pathogenic germs are constant inhabitants of the nose and nasopharynx, even in health, and it requires no stretch of imagination to assume that through an expiratory blast, such as coughing, or blowing the nose, they can be forced through the inflamed eustachian tube and thus enter the ear. When sterile water is forced into the healthy middle ear by means of a eustachian catheter, no symptoms are produced other than those of a mechanical obstruction—deafness and a feeling of fullness in the ear, which gradually pass away when the fluid is drained off by the eustachian tube. Even fluid that contains infectious material fails to produce disease so long as the mucous membrane is intact. When, however, the vitality of the middle ear has been weakened by disease, the introduction of any fluid into the middle ear, even sterile water, seldom fails to set up a pathological condition.

Acute middle ear trouble usually occurs in the course of an acute infectious disease, such as scarlet fever, measles, pneumonia or grip. Scarlet fever and measles are accountable for most ear trouble in children, while grip is the prevailing cause among adults. The pernicious nasal douche and sea bathing also claim a certain number of victims, through the suction of water into the nose and into the tubes.

In scarlet fever one child out of every three develops otitis, and of half this number the affection is bilateral. When we consider that 20 per cent. of acquired deafness is due to scarlet fever, and that most running ears can be traced to it, the importance of prompt measures in dealing with an otitis from this cause becomes apparent.

It was not until the severe epidemic of influenza in 1890 that our attention was called to the frequency with which otitis occurs in grip, and ever since that time the grip ear has been a common observation in the changeable weather of the spring and fall months. The otitis of influenza must be carefully watched, since the mastoid is implicated oftener than in the otitis following other diseases.

When, in the course of a febrile disease, an otitis arises, it usually begins towards the decline of the fever, when the vessels become relaxed and the mucous membrane pours out an inflammatory exudate. This occurs in the second week of influenza and measles and the third week of scarlet fever, the time when the physical condition is poor and the vitality of the ear enfeebled.

During an attack of any acute fever, involving the upper air tract, the cavities of the ear, in common with those of the nose and throat, become congested, and when the hyperemia resolves, an exudate is thrown out by the relaxed mucous membrane. Under ordinary circumstances the secretion from the middle ear is drained off by the eustachian tube and passes to the nose. When, however, this tube is inflamed and obstructed, the exudate cannot escape and soon fills the middle ear and mastoid cells. As the fluid accumulates, the pressure in the middle ear increases, and finally the drumhead bursts. In most instances the escape of the fluid mars the cessation of the pain and other inflammatory symptoms. Left to itself, the drum-head usually ruptures within twenty-four hours in children and between the third and fifth day in adults. In certain cases, however, the drumhead is firm and does not yield to the pressure of the exudate. When this occurs the fluid usually becomes infected by pyogenic organisms, and the infection may invade the mastoid cells and may even attack the lateral sinus. In very young children an infected exudate in the middle ear is particularly dangerous, because of the ease with which it destroys the thin shell of bone that separates the middle ear from the brain.

In children the mastoid process contains but one large cell, the antrum, and when it becomes diseased the pus frequently penetrates its bony cortex and produces the well-known periosteal abscess, so common in children, and for the relief of which Wilde's incision was devised. It is a mistake to wait for a mastoid abscess to become mature, in the hope that it will evacuate itself, for frequently, even in children, the inner wall of the mastoid process becomes eroded, instead of the outer, and the pus enters the brain cavity, after which there is no certainty of a successful issue from operative procedure.

Sometimes mastoiditis occurs in spite of every precaution and an early and free incision into the drumhead. This is when the middle ear has been shut off from the mastoid cells by inflammatory adhesions so that the pus from the cells cannot escape into the middle ear.

Such a condition is present when there is a bulging of Shrapnell's membrane and a sinking of the posterior superior canal wall. At times the bulging of Shrapnell's membrane is so pronounced that it hangs down like a polyp. In this class of cases, mastoid and even cranial involvement may occur in spite of precautionary measures.

The severity of most attacks of acute otitis depends largely upon the physical condition of the sufferer and the virulence of the infection. At one time it was thought that the most constant factor in fatal cases of otitis was the streptococcus, but further research has shown that no particular microbe is accountable for all severe infections. In those cases of otitis in which the exudate does not become infected, the drumhead may remain intact and the exudate escape by way of the tubes. Ankylosis of the ossicles from fibrous adhesions is sometimes observed in these cases when the exudate passes off.

Recurring attacks of otitis are usually observed in individuals who suffer from a disorder in the nose or throat. In children adenoids and tonsils are responsible for most recurring earaches. In adults the trouble lies in the turbinates or in the septum. Such persons readily take cold, and, with each cold, deafness and earache are experienced. These are the cases in which the underlying nasal disorder must first be cured before we can hope to benefit the otitis.

An acute attack of middle-ear disease usually begins with fever, not always. The ear throbs and feels full; and soon a sharp pain is felt, which is worse at night and when lying down. Dizziness, nausea, and annoying noises are also complained of. The ear is tender to the touch, and every movement of the head intensifies the pain. The canal of the ear is swollen and the hearing is poor. These symptoms continue to increase until the fluid escapes, then they quickly subside, providing the drainage is good. In young children the symptoms of an acute otitis may be obscure and misleading. It begins with a high fever, 103° or 104°, and perhaps with convulsions. The child is fretful, refuses to nurse or to lie upon the diseased ear, and puts its hand to the ear and rubs it. When the ear is accidentally touched, it utters a sharp scream, like a child suffering from meningitis.

The only satisfactory way to find out the true condition of the middle ear, especially in children, is by means of the ear speculum. All other methods are incomplete and misleading. In an acute otitis media, the drumhead, instead of being pearl-gray in color, is inflamed, and bulges at some point, usually at the posterior inferior quadrant. The landmarks on the drumhead are usually obliterated, excepting the short process of the malleus. Occasionally a whitish deposit of cast-off epithelium on the drumhead hides the inflamed surface, and when the deposit is removed with cotton, the true condition is revealed.

By placing a diagnostic tube into one's own ear and gently inflating the diseased ear of the patient, bubbles of air can be heard forcing their way through the fluid in the middle ear. A tuning fork placed upon the mastoid process of the diseased ear can be heard by the patient better than when placed over the mastoid process of the sound ear,—due to the better sound-conducting properties of the fluid medium.

As soon as a person complains of a severe earache we must bear in mind that we have to deal with a septic process, which is apt to assume dangerous proportions if allowed to go unchecked. The sufferer should be kept quiet, put to bed and placed upon a fluid diet, and in other ways treated as we would treat a patient with a high fever. The bowels are to be kept open, and a single dose of morphine given to insure rest and comfort. Dry heat or else an ice-bag can be applied to the ear. The former is the more acceptable to most patients. Every three hours the ear should be gently irrigated with a hot solution of bichloride 1 to 5,000, after which a few drops of a 1 per cent. solution of carboglycerin can be instilled. The pernicious practice of putting an onion, an oil, or a tincture into the external meatus should be discouraged, since it is not only useless, but harmful and uncleanly as well.

Under no consideration should a person be allowed to suffer longer than twenty-four hours. If the pain continues, and the drumhead is inflamed and distended, palliative measures are worse than useless, and any attempt to abort the inflammation by means other than surgical is dangerous, and valuable time is lost in so doing. A bulging drumhead should be treated in the same way as a septic formation in any other place. It should be freely incised, rather than simply punctured or allowed to break. This procedure not only gives prompt relief, but also prevents dangerous complications in most instances, and facilitates the reparative process. No operation in surgery is attended by greater relief and benefit than that which evacuates a distended middle ear, when properly done.

By administering a hypodermic injection of morphia or by giving a whiff of chloroform or nitrous oxide, the drumhead can be freely incised with little or no pain. The utmost care and cleanliness should be exercised in doing so, lest a mild infection be converted into a more serious one from without.

During the progress of a middle-ear trouble we must be on guard for symptoms of mastoid involvement. This is shown by a sagging of the posterior superior canal wall and tenderness over the mastoid process. The sagging of the canal wall is due to the detachment of the periosteum, and occurs only when pus has invaded the mastoid cells.—New York Medical Record.

GASTRIC LAVAGE.

By W. BROWNLEY FOSTER, M.D.

Gastroenterologist to the Memorial Hospital, Etc.

RICHMOND, VA.

In the last twenty-five years, the use of the stomach tube for both diagnosis and therapeutic purposes has become firmly established. It is generally acknowledged that the use of the tube in conjunction with test meals furnishes information of great diagnostic value and of practical applicability—information, moreover, obtainable in no other way. And, similarly, the therapeutic use of the tube in lavage is recognized as of inestimable value in the management of gastroenteric disease.

The simplicity of the necessary apparatus and of the technique, and the immediately evident results of its proper use recommend it forcefully. The only apparatus necessary is the common soft rubber stomach tube with a funnel, a pitcher for the solution and a waste basin.

The easiest tube to introduce is a fairly stiff one, with no terminal opening, but with a closed, conical end. Such tubes are not as easily cleaned as those with the terminal opening since food residues lodge in the tube beyond the eyelet and are not readily dislodged. A very flexible tube is less liable to injure the stomach than a stiff one and is to be used where injury by the tube is feared. With a very soft and flexible tube, more difficulty may be experienced in passing from the pharynx to the oesophagus and in passing the cardia. The occasional coiling of a soft tube in the mouth and stomach is productive of much discomfort to the patient and annoyance to the operator. A large tube is desirable for the early removal of a mixed meal, and in any case in which tough mucus or large food masses, like unchewed meat, solid fruits, etc., are likely to be encountered. When the food masses are very large, the end of the tube should be wide open, though a very large terminal opening making it impossible to give the tube a conical end, makes its introduction more difficult and increases the liability to injury of the stomach wall thinned by ulcer or softened by other disease. A tube of very large size produces more discomfort than a small one, and for this reason the large tube cannot always be used satisfactorily in untrained patients.

For general use, the tube should be of medium size and fairly stiff, should have a terminal opening and two large oval, lateral openings about three inches apart. The tube should be fitted with a window of glass tubing twenty-nine or thirty inches from the end. This will prove of great assistance in observing the flow of the contents. A

bulb near the middle of the tube will afford useful means of freeing the tube of large food masses which may obstruct the flow, and will be of aid in starting the flow without compelling the patient to make disagreeable straining efforts to expel the stomach contents. The bulb is also of use in securing thorough mixing of the washing fluid with the contents. For this purpose, the tube should be pinched tightly beyond the bulb and the bulb sharply compressed and released a sufficient number of times to secure thorough mixing of the contents with the washing fluid. This causes a jet of water to impinge on the stomach wall with more or less force, cleansing it of mucus and other adherent matter, and produces more or less active churning of the contents enabling us to cleanse the stomach more thoroughly and quickly and with a smaller amount of washing fluid. This process seems also to add to the tonic effect of lavage.

For the so-called stomach douching, we should employ a tube with several small (1 mm. to 2 mm.) openings and one larger hole of 3 to 4 mm., or else use Turck's sprinkling tube. This is a double tube. The inflow tube is shorter than the outflow tube, and has its end perforated with numerous small openings which serve to divide the stream into as many smaller jets. The outflow tube has large openings and keeps the stomach comparatively empty so that considerable water pressure may be used with the instrument. It is an efficient and useful appliance.

It is rarely necessary to cocaineize the pharynx before passing the tube, though it may be necessary in cases in which it is important to avoid retching, such as arteriosclerosis and ulcer. No other lubricant is to be used than water in which the tube is dipped.

When introducing the tube, have the patient sitting while the operator stands behind or to the right of the patient with the left arm around the patient's head. This position gives the operator considerable control of the patient's movements should he resist the passage of the tube or attempt to withdraw it. The head will be held firmly by the operator's arms, and both hands are free to manipulate the tube or control the patient's hands. It must not be inferred from this that a physical contest is a common incident in the introduction of the tube, for nothing would be more untrue.

No guide for the tube, such as the finger in the patient's mouth, is necessary. Simply introduce the tube, instruct the patient to swallow a few times, say a few reassuring words and gently slide in the tube. No difficulty will be experienced, except rarely at the esophago-pharyngeal junction and possibly at the cardia, where slight resistance may be felt. This resistance yields in a few moments, provided no deformity be present.

When the tube is fully inserted, before introducing any fluid, it is well to procure some of the stomach contents for examination, by having the patient express it by straining movements or by aspiration. Then, pour in through the funnel from a few ounces to a pint of irrigating solution and mix the fluid with the stomach contents by repeatedly lowering the funnel and allowing it to fill with fluid, then raising it that the fluid may flow back. When the mixing is accomplished, depress the funnel that the contents may flow out. Straining efforts by the patient will start the flow. Several causes may interfere with the flow, such as blocking of the tube with solid matter, the viscosity of the stomach contents from mucus, etc. The end of the tube may not be introduced as far as the surface of the liquid in the stomach, or it may be introduced too far so as to be deflected above the surface of the stomach contents. A plugged tube may be opened by squeezing the bulb after pinching the tube beyond it, or by introducing a little more water. In cases of gastroptosis and dilatation, it is necessary to introduce varying lengths of tube until the proper level is reached. Fresh portions of fluid are introduced and withdrawn until it returns perfectly clear. Be careful to withdraw all the fluid before introducing more. Do not overdilend the stomach.

In withdrawing the tube, hold it occluded by pinching it with the fingers so as to prevent strangling the patient or soiling the room furnishings with any contents remaining in the tube. The tubes are not injured by steam sterilization or boiling.

Lavage is not a cureall. It is not indicated in all gastric diseases, and is not necessary in all in which its use sometimes proves beneficial. Its radical curative properties are not so important as the fact that it relieves the stomach of impossible tasks while nature's recuperative forces accomplish the cure. Its beneficial effects are due to three chief actions: 1st, mechanical and chemical cleansing and antiseptis; 2nd, securing rest for the stomach; 3rd, tonic effects.

Mechanical cleansing rids the stomach of indigestible or decomposing food and excessive mucus. Cultures of active microorganisms are removed mechanically. Those germs left in the stomach have their food supply removed temporarily and are treated with active antiseptic agents.

Absolute rest is secured for the stomach from the time lavage is performed until the ingestion of the next meal. Rest for the stomach is as necessary for its welfare as it is for the organism as a whole or for any other organ. Its importance cannot be overestimated; and its beneficence is shown by the striking results of abstinence from food in acute gastritis. In severe motor insufficiency, pyloric stenosis, etc., when the stomach is never free from food, it can secure rest

only by the stomach tube or by gastroenterostomy or by abstinence from food by the mouth aided by the weak crutch of rectal alimentation.

Tonic effects may be secured by the use of sprinkling tubes, by varying the temperature of the solution used and by the employment of certain medicaments.

By lavage we remove noxious matter. Only in cases of poisoning or of acute gastritis from indigestible or tainted food, does lavage actually remove the prime cause of the disease. Yet, in many cases of gastric and intestinal disease, the putrid, fermenting, acrid, indigestible stomach contents are the chief agent, prolonging the trouble and causing distressing symptoms. In such cases, the removal of the contents of the stomach may give almost instantaneous relief from suffering, and repeated lavage be the means of restoration to health. A small amount of fermenting matter left in the stomach from the last meal, containing, as it does, active bacterial ferments, will leaven each succeeding meal, so that bacterial action will not only continue but increase. Lavage promptly abolishes the resulting toxemia. The mechanical action of the fluid impinging on the stomach wall with more or less force is akin to the highly stimulating effect of a jet of water directed onto the cutaneous surface of the body. This effect may be readily modified by producing a number of fine jets with a sprinkling tube. The alternate distension and emptying of the viscus as the water is admitted and withdrawn, is akin to massage and exercise.

By using solutions of different temperatures, the effects of lavage may be varied much in the same manner as hot and cold baths differ in effects. The maximum of thermal stimulation is produced by the alternate use of hot and cold solutions, the temperatures being about 140°F. and 45°F., respectively; and the least by solutions of body temperature. The use of hot solution may be necessary in severe hyperchlorhydria. The temperature, at first, should be about 110°F. and be gradually increased, but never above 140°F. Due regard should be had for the patient's sensations. A return flow tube is convenient for this purpose. Care should be used in the employment of very hot or very cold solutions, and appropriate hydropathic procedures may be used to combat any untoward general effect. In particular, a cold compress over the precordium may be used to counteract the excited heart action which may result from the use of hot solutions in the stomach.

If our sole intention in washing the stomach is to remove fermenting, poisonous, indigestible matter—simply, to cleanse the stomach—plain, lukewarm water will serve the purpose. But there are cases in

which great benefit will accrue from the addition of other substances to the water. When much tenacious mucus is present, the addition of sodium bicarbonate (one teaspoonful to the quart) will greatly aid in its removal. Dilute hydrogen peroxide is also efficient for this purpose. Normal saline solution is an excellent cleaning agent and is less irritant than most solutions. Stronger salt solutions (from a teaspoonful to a tablespoonful to the quart) are of some value as stimulants of secretion; and dilute hydrochloric acid (about 0.2 per cent.) is also of value for this purpose. This twentieth normal hydrochloric acid is of use in motor insufficiency with hypochlorhydria; and if about half a pint be left in the stomach, it will have an appreciable influence in ridding the stomach of those micro-organisms whose presence is due to the deficiency of hydrochloric acid in the secretion. The solution may be prepared by diluting the official dilute hydrochloric acid with about fifty volumes of water.

A great number of antiseptic drugs are recommended as efficient in ridding the stomach of objectionable microorganisms and so stopping bacterial fermentation. Many of those agents, while efficient, are objectionable because of their toxicity. To this class belong phenol, lysol, creolin, etc. Such agents are to be strongly condemned for general use. If any drug of marked toxicity be used in lavage, it is well not to use over times the safe internal dose of the agent. It is conceivable that a fourth of the solution used may either pass through the pylorus into the intestine during the operation, or else be left in the stomach because of the difficulty of withdrawing all of the solution through the tube. Another precaution of self evident importance is to wash the stomach with a non-toxic agent immediately after the use of a toxic one. This non-toxic agent need not of necessity be plain water, as we may use some of the milder drugs with the desired action. To remove a toxic antiseptic, we may use a non-toxic antiseptic; to remove nux vomica, we might use some simple bitter. If the local use of the more toxic drugs is deemed necessary, they may be applied with the intragastric spray apparatus, smaller amounts being effective than are requisite by irrigation.

The most useful antiseptics are salicylic acid, boric acid, thymol and hydrogen peroxide. Menthol has both antiseptic and analgesic properties. Salicylic acid is one of the best of these. It dissolves in water with difficulty, but the solutions may be prepared with ease if the acid is first dissolved in alcohol. One ounce of salicylic acid may be dissolved in enough alcohol to make about four fluid ounces, and one to three fluid drams of this solution added to each quart of water. The solution will then contain about one to three parts per thousand. This is one of the best agents for combating gaseous fermentation.

Silver nitrate, in the proportion of about one part per thousand, is of great value in hyperchlorhydria. Irrigations with this drug often markedly decrease the acidity and soothe the mucous membrane. Staining of the hands by silver solutions may be prevented by anointing the hands with petrolatum before the lavage. Silver solutions injure rubber goods and increase the necessity of cleansing the tubes immediately after use. The organic silver salts may be used instead of silver nitrate.

In sensory neuroses, lavage with chloroform water may be productive of great good. Its analgesic effect is marked.

In the atonic conditions, motor insufficiency, hypochlorhydria and hyposecretion, irrigations with *nux vomica* and other bitters, especially *cinchona*, *gentian* and *condurango*, have given me highly gratifying results. Probably the best technique is to perform a cleansing lavage with warm, normal saline solution. Then, with some sprinkling tube, introduce a pint of water containing one fluidram of *tr. nucis vomicae* allowing it to remain a few minutes; and then wash out this solution with an abundance of a solution of tincture of *cinchona*, one fluidram to each pint.

The time to be chosen for the performance of lavage must vary according to circumstances. In general, the best time is about half to one hour before the evening meal, the next choice being bed time, and, lastly, before breakfast. Each time has certain advantages and disadvantages. The hour before supper is most convenient for the physicians, though a capable nurse, if accessible, may perform lavage at any desired hour. Morning lavage has the disadvantage of not assuring rest for the stomach during the night. The usual reasons assigned for choosing the morning hour are that at this time, less nutritive matter will be removed than at any other period, and that the stomach is cleansed and partly sterilized in preparation for the day's digestive task. The reasons for performing lavage at bed time are that by it, the stomach is emptied and cleansed for a long period of rest and recuperation from the fatigue of the day's digestive work. But, to me it seems that the sum of these advantages is in favor of the washing before supper. The washing is done at a sufficiently long period after dinner for gastric digestion to have run its normal course. If the meal be allowed to remain longer in the stomach, stagnation and fermentation ensue. The mass of food, mucus, etc., becomes so acrid and foul that its removal cannot be regarded as a curtailment of the body's available food supply, but, rather, as the voiding of useless, noxious, effete matter. Furthermore, the nutritive material removed by the tube may be replaced by a suitable and greater portion of fresh and healthful food. If the foul remains of the dinner be allow-

ed to remain, they will contaminate the pure supper so that its digestion cannot be normal. Rest for the stomach during the night may be secured by the administration of a supper of such quality and quantity as the crippled organ can easily dispose of in a few hours.

If food be found in the stomach in the morning after the administration of such a meal, or if the evening wash prove insufficient from any cause whatever, the lavage may be repeated before breakfast. If lavage is indicated for relief of insomnia caused by fermentation or acidity, it should be performed at bedtime.

If the patient lose weight under lavage before supper, and the loss of weight seems to be continued by removal of food by lavage, we should change the time to the morning hour.

Lavage should not be reserved for those severest cases of gastric disease in which the stomach never is free of food, but should be used in every case in which the stomach is unable to dispose of a reasonably full dinner before supper time—that is, in six, or at most seven, hours.

Stasis, fermentation, gas formation, the presence of excessive mucus, of active cultures of yeasts, sarcinae, Boas-Oppler bacilli and other microorganisms are also indications for lavage. They occur in such conditions as motor insufficiency, atonic dilation, mucous gastritis, pyloric stenosis and cancer. Lavage, if properly performed for these indications, will surely give good results. It is also of great use in acute gastritis, poisoning, acute alcoholism and the crises of hyperchlorhydria and locomotor ataxia. It is seldom needed in uncomplicated hypochlorhydria but when this condition is complicated by atony, it may be necessary.

Occasionally, though rarely, the stomach tube must be used in cases of gastric ulcer, or of varicose gastric or esophageal veins, such as occur in conditions obstructing the portal circulation. In such cases, we must use the softest, smoothest and most flexible tube obtainable, and one without the terminal opening. Even with such a tube, the greatest care and gentleness are necessary to avoid injury. It is quite possible that perforation of the ulcer-eaten area may occur as the result of careless handling of the tube, or that high grade hemorrhage may result from an abrasion of a dilated vein. It is of the greatest importance that the tube should not be removed from the stomach nor inserted further while aspiration is being used, or while fluid is flowing from the stomach.

I have seen portions of healthy mucous membrane torn off, with the production of considerable hemorrhage, by moving the tube during aspiration; but it is my experience that none of these mishaps have been alarming or productive of trouble. Most of the fragments of

membrane brought forth by the tube are not healthy tissue, and are the evidence of an exfoliative gastritis or Einhorn's gastric erosion. Occasionally, when the tube is withdrawn, a few small blood clots are found in the eyelets. They are without significance.

The contraindications of the use of the stomach tube are such local conditions as active gastric ulcer, gastric hemorrhage, local peritonitis or other local inflammation. Among the general contraindications are severe valvular heart disease, fatty degeneration of the heart and arteriosclerosis. Fatal accidents from the use of the tube are, happily, very rare indeed, and are usually results of violent retching—such, for example, as rupture of the stomach or rupture of aneurysms, etc., from high blood pressure incident to the strain of severe retching. Cases in which such accidents are likely, may usually be recognized at a glance, and calamitous accidents from the intelligent practice of lavage are rare indeed.—Southern Med. and Sur. Jour.

TYPES OF HYSTERICAL INSANITY.

At the meeting of the New York Neurological Society, October 3rd, 1905, Dr. Robert C. Woodman read a paper on the outcome of a symptomatic study of the insanities during the past two and a half years. Cases not clearly belonging to any well recognized insane type had been especially scrutinized, and some had been found to show hysterical stigmata, while other atypical cases without stigmata presented mental symptoms very similar to those of the hysterics. His observation and study had shown that there were among the committed insane a considerable number of hysterics, and those cases were, in many instances, violently insane for considerable periods. Any medical classification that ignored that fact was incomplete, and concealed important clinical distinctions. The recognition that some hysterics, as such, were insane, helped to bridge the gap between mental diseases and general medicine, and made more easy the conception of other insanities as thinking disorders; as functional in the same sense as ordinary thought was functional.

Dr. Woodman's paper, in summary, analyzed the symptoms that insane hysterics presented. He found the origin of the attack in emotional experiences; it pursued an episodic course; there was an absence of marked disturbance in the stream of thought, excepting in dazed and stuporous states; there was a natural point of view con-

cerning indifferent topics; often periodic amnesia; a loss of the ability to do mental or physical work, but with little or no motor retardation, and, on the emotional side, usually anxiety and fear. Cases were quoted in which the anxious depression preceded the hysterical stigmata, notably in one involuntional case, and the question of a close relation of hysteria to anxious depressions at any time of life was raised, especially as to its relationship to current melancholic attacks without manic alternations. Some non-conclusive evidence on the relation of hysteria and dementia praecox was submitted, and some other symptom complexes which hysteria had been found to take were referred to.—Journ. A. M. A.

CHRONIC DIARRHEA.

R. W. Wilcox (American Medicine, June 10, 1905) gives the following synopsis: Diarrhea being a symptom, the cause should be ascertained. This may be (1) mechanical; (2) nervous; or (3) hemic. Under each division there are subdivisions, each subdivision representing an etiologic factor, which is the basis for treatment. The last should be considered under (1) dietetic; (2) hygienic; (3) medicinal. Certain remedies and methods should be avoided. Opium is only admissible when the alimentary canal has been thoroughly emptied to check excessive peristalsis. It should be given hypodermically as morphine, in substantial doses, and not repeated. A prescription for opium or any of its preparations or alkaloids should never be entrusted to nervous patients; there is too great danger of habit formation. The tannin preparations are sometimes useful in precisely the same way that they are useful as antidotes in alkaloidal poisoning, by temporarily inhibiting the action of bacteria and their toxins. Bismuth naphtholate, bismuth tribromophenolate, and bismuth tetraiodophenolphthaleinate are more effective. Wilcox emphasizes the importance of recognizing that the diarrhea is not always due to demonstrable changes in the alimentary tract. Much as we dislike to present symptom treatment, yet pending further knowledge we must divide diarrheas into classes, based upon their causation, and then proceed to treat them intelligently.

HEAVY COLDS.

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RELIEF OF SCIATIC PAIN.

We wish to refer to a comparatively new combination of drugs, one which has been used largely for the control of cough and which has also been employed to a great extent for the relief of pain. It is claimed that its use in many cases renders the same service as does morphine, its influence often lasting for as long a period of time, and possessing the advantage that it does not disturb the digestive tract, nor cause constipation or habit. The remedy we mean is Antikamnia and Codeine Tablets. In several instances in which the patients were suffering from severe acute sciatica, it was found that they acted most satisfactorily. Each tablet contains 43-4 grains of antikamnia and one-fourth grain codeine sulphate. The prompt and excellent result obtained with this preparation is due, in a great measure, to the specially refined and purified codeia which The Antikamnia Chemical Company employs in these tablets. Impure or ordinary codeia irritates, constipates and depresses, and to avoid this, the said Company purifies its codeia by a special process, and this should be remembered by the physician when prescribing codeia. In treating a case of sciatica, one tablet was followed by a diminution of pain, and after the third tablet, given in half-hour intervals, the pain entirely disappeared. The usual dose is one tablet every two, three or four hours, according to indication.

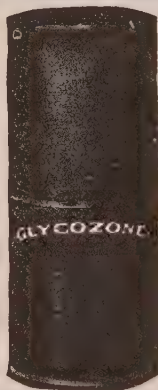
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The State Medical Association.

The State Medical Association of Alabama will convene in this city on the third Tuesday in April. The local physicians are already discussing the matter of entertaining the physicians who may attend the association. It is the desire of the members of the Jefferson County Medical Society that everything be done which will contribute to the pleasure and interest of the meeting, and it is to be hoped that the medical profession throughout the State will attend. Of course it is too early for the program to be printed, but all who know our distinguished President, Dr. E. D. Bondurant, of Mobile, feel sure that the papers which will be contributed, will be of a high

order, and the Journal takes advantage of this early date to extend the most hearty invitation and to urge every physician in the State who can possibly do so, to be with us on this occasion. The hotel accommodations are, we think, ample to meet all demands, and in order that some who are not acquainted may be familiar with the names of the leading hotels, we mention them so as many who may desire to engage rooms previous to the meeting may do so. The Colonial Hotel on Twenty-First Street between Second and Third Avenues, Hotel Hillman on Nineteenth Street between Third and Fourth Avenues, St. Nicholas on Nineteenth Street between First and Second Avenues, the Morris Hotel on the corner of First Avenue and Nineteenth Street, the New Birmingham on Eighteenth Street and Second Avenue and the Metropolitan on Twentieth Street. These hotels are all modern in equipments, well lighted, well heated and good elevator service. We hope next month to be able to give the reduced rates that no doubt these hotels will grant to the members of the profession.

The Banquet.

The annual dinner given by the Jefferson County Medical Society at the "Hotel Birmingham" last month was one of the most delightful functions which this Society has enjoyed in many years. The beautiful new dining room was filled to its capacity. The service and menu furnished by the Birmingham Hotel was in every way satisfactory to all the doctors present. Dr. Lewis C. Morris, the newly elected President, acted as toastmaster and did his part well. A large number of doctors responded to toasts and added much to the pleasure of the occasion. The Jefferson County Medical Society is the largest local Society in the South, composed of nearly two hundred active physicians, and the harmony and good fellowship which is shown at these annual meetings is very gratifying. The Journal hopes that this good fellowship, especially characteristic of the Jefferson County Medical Society, will continue for many years to come, and that the Jefferson County Society will also be recognized as one of the best medical scientific working bodies in the South,

On to Boston.

It is the purpose of the Alabama Medical Journal to arrange a special car at the very best price which can be secured to run from Birmingham to Boston for the physicians of Alabama, who may desire to attend the next meeting of the American Medical Association. We hope to be able to secure a good rate for the physicians and if a sufficient number indicate to us their desire to go in a body on this special car, the arrangements will be made and full particulars will be given later on. We will be glad to hear from any physician who contemplates making this trip and attending the meeting of the association, and if they would care to take part in the special car. We are agitating this question because we think it would be a delightful trip for twenty or twenty-five of Alabama doctors to go in a body. We will have something more to say in regard to this special car next month.

Patent Medicines.

At the last meeting of the Jefferson County Medical Society, Dr. Snyder of this city, read a paper on the subject of Patent Medicines. The President, Dr. Lewis C. Morris, so we are informed suggested the discussion of this subject and the author of the paper invited to be present the editors of a number of newspapers and the ministers of the city. Most of Dr. Snyder's paper was devoted to the Patent Medicine Nostrums, showing that most of them were compounds containing alcohol and morphine or some form of opium. He was most especially severe in his criticism of the two religious papers published in the city and devoted much space to the number of advertisements which these were carrying and stated that he had called the attention of the editors to these advertisements and that they had had a conference on the subject.

Dr. Snyder in his paper stated that the medical profession had been accused of harboring much skepticism with reference to religious matters. Denying the breadth of this charge the author suggested that, in the special instances of skepticism among physicians, one of the chief causes for their unbelief was the inconsistency on the part

of many leading ministers in their conduct of religious papers and the endorsements given by many of them to Patent Medicine Nostrums.

At the conclusion of the reading of the paper, all present were granted the privilege of the floor, and the editors of the two papers which had been severely criticised, both addressed the Medical Society, endorsing the paper, and insisting that if the advertisements which they were carrying were contrary to the best moral interest of the people, that they would discontinue them as rapidly as the contracts now existing expired. One of the editors stated that he was the owner and proprietor of one of the papers which represented one hundred and fifty thousand church people in Alabama, and being convinced of the wrong which might exist from the publication of such advertisements, he would rather discontinue them, if it required the sacrifice of his paper. One of the editors of the leading daily paper of the city stated that he had many applications for questionable advertisements of the character under discussion, but he made it a rule to turn them all down. Dr. E. H. Sholl stated he had read a paper on the subject two years ago, which was published in the Alabama Medical Journal, in which he criticised these advertisements in several of the religious papers of different denominations, but so far as he knew, he could not see that any good had been accomplished. The sentiment of those present, judging from the large number who spoke on the question, is certainly strong against this great evil. The Journal of the American Medical Association and a large number of other Journals are from time to time giving space in discussing this question. Colliers Weekly, the Ladies Home Journal and other papers are convinced of the evil which is being done by the enormous sale of Patent Medicine Nostrums and are doing much to educate the people against it. In our opinion, it is the beginning of a great educational movement which will ultimately give satisfactory results. Reforms of this character, however, are to be made slowly and firmly, but if the doctors, who are more than convinced of the damage to humanity by the use of patent medicines, will do their duty the time will come when the patent medicine subject will be a thing of the past.

Miscellaneous Notes.

NOTE ON CHALYBEATE THERAPY

By William Krauss, PH. G., M. D., Memphis, Tenn.

There have been volumes written on chalybeate therapy and the controversies upon the absorbability of this or that form of iron have occupied the attention of clinicians for many years. Among the many preparations claiming the attention of clinicians, the one devised by Dr. Gude, chemist, of Leipzig, has received the endorsement of the ablest men on both continents for ten years. The writer has used it to the exclusion of all others, with the exception of a few disappointing experiments with others claiming equal merit, and has published two papers upon the subject.

It would seem that when one has used a certain medicament for years and with uniformly good results, and especially if this agent definitely eliminates the shortcomings of formerly employed products of the same elements, one is apt to take its effects as a matter of course, and further discussion would seem useless, or at least superfluous. When it happens, however, as is usually the case after a certain article has had a successful career, that many similar products strive to take the place of the original, generally resulting in disappointment to the user, it becomes a duty to take stock of the evidence in the case and see how far the confidence in the one and the distrust of the other is justified.

For this reason I have had compiled from separates and reprints some of the results of a few trustworthy observers.

1. Secondary Anemia.—H. D. Peterson (Chicago Medical Recorder, 1896), treated many cases, reporting 5 in detail, and says: "Pepto-Mangan is easily absorbed by the digestive tract without any disturbance of the same, is not injurious to the teeth, and produces no constipation."

Dr. J. W. Frieser, Vienna (Therapeutische Monatshefte, February, 1902), reports treating many cases, among which he made detailed studies upon 43 cases and summarizes: "It can be warmly recommended for extensive use in the treatment of anemic conditions."

Dr. Hugo Summa, St. Louis (N. Y. Medical Journal, 1895), recommends its use after tests in 34 cases, saying: "It is especially worth mentioning that no bad after-effects could be detected. In this connection I call special attention to the absence of constipation that could be traced back to the use of this preparation."

Dr. Sam'l Wolfe, Philadelphia, reports upon 50 cases observed during about four months, and concludes: "That Pepto-Mangan is a highly available preparation of iron, on account of its liquid form, pleasant to taste, non-corrosive action on the teeth and unirritating effect on the digestive organs, admitting thus of easy gradation of dose, easy administration to children and avoidance of unpleasant effects in all cases. That it is an efficient and rapid restorer of the normal quantity and quality of the blood, etc."

Dr. Fritz Euler-Rolle, Vienna (Wiener Klin. Rundschau, March 29, 1903), mentions 14 cases of anemia, besides a number of cases of other diseases, in a very complete report in which he is pleased with its absorbability and (on account of the abundance of peptone it contains) its food value in delicate stomachs, and finds it free from all the objections usually urged against iron preparations, and its results prompt.

Dr. C. A. von Ramdohr (N. Y. Medical Journal, June 26, 1897), in connection with some gynecological cases, reports 7 cases of anemia, in which there was a rapid improvement.

Dr. H. P. Loomis, in a paper before the New York Academy of Medicine (June 18, 1893), reports a number of cases, 8 in detail, in whom there was a rapid increase in red cells and hemoglobin, and in most cases with no constipating effect.

Drs. Diago and Benitez, Superintendent and Chief of Laboratory, Hospital No. 1, Havana, Cuba (Progreso Medico, Havana, April, 1902), report 6 cases in detail and summarize as follows: "We may say conscientiously that it is the best remedy we know of for the purpose, and that we do not hesitate to commend it to the profession especially our confreres in Cuba, as an iron preparation that possesses all the advantages that can be demanded of such a remedy and none of the disadvantages that are characteristic of other iron preparations. We would especially emphasize also that Pepto-Mangan (Gude) is very pleasant to the taste, and is most easily taken by patients of all ages and with the most delicate digestions."

Dr. Juan Pablo Garcia, Havana (La Revista Medica Cubana, August 1, 1902), says: "I have had the opportunity of testing the efficiency of this preparation of iron in a large number of cases in both hospital and private practice, and have found it the most satisfactory iron compound that has come under my notice. It is not at all constipating, its taste is not astringent, so that it lacks the great disadvantages of most other iron compounds." He says further that it causes no disturbances of digestion and its therapeutic efficiency has been attested by the best clinicians throughout the world.

Dr. Louis J. Gravel, Physician-in-Chief to the Hotel Dieu, Montreal (Buffalo Med. Jour., August, 1903), prefers the term dysemia, mean-

ing "bad blood," reports 13 cases with blood examination, and says: "Comparing my results with Pepto-Mangan (Gude) with those obtained from other chalybeates of this class, I have been led to give it decided preference."

Drs. Chibas and George A. de Santos Saxe, of Columbus Hospital, New York (*Int. Jour. Surg.*, June, 1903), reports 40 cases, with tabulated results and complete bibliographic review (which has facilitated this complication very much), in anemic convalescents with uniformly satisfactory results. "In no case did constipation, nausea, headache, or digestive difficulties follow its administration."

Dr. Hermann Metall, Assistant Physician at the General Polyclinic, Vienna (*Med. Chir. Centralblatt*, January, 1902), reports 23 cases of anemia consequent upon a variety of conditions, of which 12 showed a normal hemoglobin per cent. after 14 days, 5 after 3 weeks, and 3 after a month. He concludes that it is "reliable and valuable blood-building remedy, which can be recommended for general use in appropriate cases."

Anemia Consequent Upon Special Conditions.—Dr. Mateo M. Guilen, at Randall's Island Children's Hospital, gives a tabulated report of 32 cases of infantile anemia with very elaborate blood-chart, including some very desperate cases of cachexias, and says: "In no case did we have to suspend treatment on account of any untoward influence on the delicate organisms of sick infants." Three cases classed as hopeless made a complete recovery. The paper is very instructive.

Dr. J. M. Frieser (*vide Supra*) also reports great success in infantile anemia.

Dr. J. K. Bauduy (*St. Louis Medical Review*, February 26, 1898), reports upon a number of cases of neurasthenia, 12 of them in detail, with blood examinations by Dr. Carl Fisch, and says: ". . . the results, however, were indeed a surprise to myself, for the concomitant deranging sequelae were so slight that but in very few instances in my extensive utilization . . . was I obliged to discontinue it. . . . this particular remedy, I am now convinced, will prove a great boon to the patient and the physician. . . . of course we do not consider the remedy applicable to cases of lithemic neurasthenia, nor in any manner a specific in any variety of neurasthenia."

Dr. Ludwig Pohl, City Physician, Vienna (*Aertzl. Centr. Anzeiger*, September 20, 1899), has used Pepto-Mangan (Gude) in over 100 cases of chlorosis, anemia, neurasthenia, hysteria and malarial cachexia, and says: "I have previously mentioned that it may be positively assumed that Pepto-Mangan (Gude) stimulates the hemopoietic organs to increased activity. . . . Decided amelioration in the leu-

kemic state, arrest of the process in severe cases for a long time, reduction of the glandular swellings, improvement in the relation between the red and white corpuscles, were noted by me in several cases."

Dr. J. S. Perekhan (Chicago Clinical Recorder, 1896), reports a number of cases, 6 in detail; Dr. C. A. von Ramdohr (vide ref, supra), 12 cases in detail; and Dr. Gellhorn, at Mackenroth's Clinic, Berlin (Therap. Monatshefte, 1897), mentions 60 cases, some in detail, all of gynecological patients with a variety of conditions, some post-operative, and all testify to the improved blood findings, Dr. Gellhorn concluding as follows: "I feel justified in asserting that in my therapeutic trials with Pepto-Mangan I obtained all that can be rationally demanded."

In surgical conditions calling for improvement in the blood, Drs. Stuart McGuire (Vir. Med. Semi-Monthly), 20 cases, and George G. Van Schaick (N. Y. Med. Journal, June 2, 1900), 50 cases, reported favorable results. The latter concludes: "We have in such preparation as Pepto-Mangan (Gude) a means of obtaining good results with a certainty that is almost mathematical, and without any of the distressing symptoms so frequently following the use of the inorganic iron preparations."

Dr. H. Edwin Lewis, Burlington, Vt. (Vt. Med. Monthly,) Dr. Ed. C. Hill, Denver, Dr. W. O. Davis (N. Y. Int. Journal Surg., September, 1902), together with some of the authors already mentioned call especial attention to the value of the preparation in irregular menstruation, sterility and other sexual anemias in women.

Dr. Karl von Ruck (N. Y. Medical Journal) finds in Pepto-Mangan (Gude) the best preparation in the anemia of tuberculosis, being more efficient and more easily borne; he had used it in 70 cases, 12 being reported in detail, in some of which comparative tests were made with other iron preparations. Other observers also mention it in tubercular anemia.

Cachexia finds especial mention by Fritz Euler Rolle, Pohl, and Fasano, the latter professor at Royal University, Naples (Arch. Int. di Med. e Chir., March, 1899), discusses iron medication in detail, calling special attention to the chemistry of the subject and reports having treated primary anemia, 20 cases; chlorosis, 25 cases; malarial anemia, 7 cases; tubercular anemia, 8 cases; uterine diseases, 11 cases; scrofulosis, 12 cases; rachitis, 10 cases; convalescents of exhausting diseases, 15; total, 108 cases. He says: "To recapitulate, Pepto-Mangan (Gude) not only deserves the place it has already acquired in therapeutics, but it merits even greater recognition, because all clinicians ought to make use of it in pathological processes in which the

object is to restore to its normal condition the altered quality of the blood."

After this array of evidence it is only necessary to add that since this constitutes about all the clinical literature upon which our knowledge of the subject is based, it is rather significant that it was all done upon this particular product. In no instance is it claimed that the preparation is as good as something else, but it is simply set forth by the observers that this was the preparation used and that it met these indications in the manner described. Since there is no official preparation that meets these requirements the manufacturers of Pepto-Mangan (Gude) deserve all the credit which the product has earned for them.—Charlotte Med. Journal.

THE EVOLUTION OF THE TRAINED NURSE.

(Address to Graduating Nurses.)

By Herman E. Hayd, M. D., M. R. C. S., Eng., Buffalo, N. Y.

You are now separating yourselves from this institution and severing ties and associations which will always be among the pleasanter memories of your lives, and you are giving up daily companionship with friends and teachers who have contributed much to your education and to the vast storehouse of practical knowledge which will enable you to fill useful lives in the community. Your work is but begun and your real duties and responsibilities have just commenced. Here you have had your superintendent and medical staff to encourage you and to protect you, but soon you will be dependent upon your own exertions and will be compelled to utilize your studies and experiences in the competitive and exacting walks of life. The motives which prompted you to take up the noble profession of nursing must have been generous ones, and you have realized by this time that your life work, if it is to be successful, must be one largely of self-sacrifice and self-abnegation. Few people know how difficult and exacting your duties are, and fewer still will grant you that appreciation and reward which you deserve. The nervous tension associated with your work, the long vigil and loss of sleep consequent upon its performance, the tax upon your physical strength and endurance in waiting upon the acutely sick and helpless, too soon make their terrible impressions upon your constitution and render you unfit for the further discharge of your duties. Your professional life, therefore, at best is not a long one, and it behooves you to take early warning that in order to serve others you must also nurse yourselves. Adopt at once habits of regularity and insist upon getting rest, sleep and a certain amount of recreation, amusement and exer-

cise. No matter how important your case may be, let it be early understood that a certain portion of the day must be given to you for outdoor life.

The compensation paid a nurse to-day is ample and is sufficient to meet all her wants and reasonable demands. You will often be called upon to give your services for less than the usually allowed amount, and when the people are poor and deserving respond at once and willingly. The possibilities of your profession are unbounded and the calls which may be made upon your talents and services know no limitations. Your work opens for you all the treasures of an exalted womanhood. Your services will not be confined simply to sickroom in times of peace and plenty, but they may be demanded during the season of scourge and famine. You may be called to the battlefield and suffer all kinds of privations—to nurse in fevered hospitals, in tents and in wagons, the soldiers and sailors who have been called in defense of your country and its flag; and perhaps be forced even into the firing line amidst the most sickening sights of carnage and death, to move about as angels of mercy, giving here and there help and comfort to the wounded and dying.

Nature has endowed women with her richest and most honorable instincts and attributes. She has filled your natures with emotions—tenderness, gentleness, sympathy and kindness—and your education as nurses gives you the opportunities to use these noble qualities advantageously. When the Lord created man he exercised a divine fiat: "In the sweat of thy face shalt thou eat bread," and you were to be his companion and helpmate, wife, mother and nurse. Through years of varying social condition and the unnatural and unfair accumulation and distribution of wealth, and through sickness, misfortune and adversity of the male supporting members of society, necessity has compelled woman to seek employment for a livelihood and to be dependent upon herself for her maintenance and support. Various occupations from time to time have opened their portals to you, and as a result women have become in a large measure the world's breadwinners. As in other fields of labor, so here, there has been a gradual evolution in the development of the so-called nurse. At first her duties and responsibilities were few and small and she was simply an ordinary domestic servant. The necessities and claims of the sick increased her possible usefulness, and then demanded of her more exacting duties and responsibilities, and as a result there was developed a position for a refined and educated woman, who in time sought a technical training, and consequently there was initiated in connection with hospitals various training schools from which men and women were graduated and were given diplomas that guaranteed the

standing, excellence and qualifications of the persons who possessed them.

This is the position you find yourself in to-night.

Let us turn for a few moments to the more practical part of our subject and ask ourselves what constitutes a good nurse. Above all, she must be a woman of character and be pure in thought and life. She must possess and must always cultivate a kindly disposition; be patient and be full of forbearance and sympathy. She must have the power to control her temper under the most distressing and often aggravating circumstances; she must be cheerful, bright and entertaining, but at the same time serious and resolute when necessary. She must be tactful, not arrogant and boastful; she must not be too communicative, neither too secretive, but always honest and truthful. The secrets of your patient and the trials of the bedchamber shall be inviolate in your keeping. She must be intelligent and studious; she must be cleanly about herself, and endeavor at all times to be neat and attractive but not fussy. She must be capable, not only in her ministrations upon the sick, but in preparing and serving their food. Present their meals in a dainty and attractive manner as possible; a nice tray with a clean napkin, and dishes garnished with some greens or fresh blossoms. Even in the homes of the poor little delicacies can occasionally be served, and in an appetizing manner; and no matter how poor and humble your patient may be, these little gentle attentions come like sweet messengers of love and hope and bring cheer and tranquility to mind and body.

A nurse with a seriously sick patient should be calm, cheerful and hopeful. These qualities encourage and strengthen and fortify in the desperate fight they are making. She should move about the room quietly, but not stealthily; she should speak plainly and directly, and her manipulations with the patient should be firm and with every evidence of confidence in herself. She should be ready at all times to answer the patient's demands and make her feel that the service is given kindly and with tenderness and affection. Don't answer back quickly and in a spirit of retaliation. Don't slam doors and make unnecessary noises either in walking or doing your several duties. Often your patients will disturb you from your sleep, and unnecessarily, but remember this is their privilege, and you must at once respond to their calls or if possible tactfully soothe them by a kind word. They will tax your patience beyond endurance like a peevish, irritable child, and no matter what you do for them they will demand something else or wish it done in a different way. A quick word or a sharp answer will wound so deeply that your future devotion, no matter how kind and slavish it may be, will not rehabilitate yourself in their confidence and affection. Better resign from the

case and have some new blood with fresh patience and new cheer and new hopes in the sickroom, because temperature, increased pulse, loss of appetite and even serious symptoms can be kept up because of these often slight and trivial disturbances. Of course, to serve such a patient will tax all human endurance and understanding, and yet if you always have in your mind an ideal nurse and a noble woman you will establish for yourself such a standard of excellence that there will be fewer complaints and your popularity will increase and your patients will get well and will have no other in attendance in their families, and the doctor will bless and thank you a hundred times for your courage and for your tact, and above all for your successful management of his case. Be loyal to your friends and to your profession. Protect your fellow nurses. Don't gossip about them or other people or engage yourself in unseemly conversation, no matter what encouragement you may get from your patient, because just as soon as you place yourself on a par with their standard of virtue and morality you detract from your own strength and usefulness.

Uphold your doctor, or resign from the case if you feel that his practice is below your standard of excellence and you cannot serve with him. Do not hint by suggestion or innuendo that Dr. So-and-so does so and so, because there are many different ways in the methods and management of diseases and you are not familiar with all of them, nor have you the knowledge necessary to qualify you to question them. However, it may occur to you in the nursing of a case that your previous experience enables you to teach the medical attendant many things which your technical training has specially fitted you for, such as the administration of baths, packs, douches, etc. He would indeed be a fool who would not accept your suggestions and perhaps wisdom. But be careful to make these remarks in an anteroom, so that the patient's tranquillity of mind and confidence are not disturbed.

Your position in the sickroom, although a noble one, is often an exceedingly difficult and trying and unjust one to fill. The doctor receives the honors and the glory and often they come through your hands. He comes into the room for a few moments and brings sunshine, and when he leaves he often takes with him the only ray that you had kindled and started aglow. Your colossal efforts to sustain and encourage when hope is gone through the wearying weeks and months of slow but sure dissolution are often beautiful, and have more than once made me feel that woman's stream of perpetual beauty and sweetness seems to be inexhaustable. Your reward is small and not commensurate with your deserts, and the only compensation you often have is the consciousness of duty well performed. But your

privileges are great. Into your arms the new-born babe is given, and from them it is placed upon the mother's breast; and from your gentle hands comfort is dispensed and light and cheer throughout succeeding periods, and finally when old age comes with its increasing infirmities you can give support and surcease during that long journey—perhaps of pain and suffering—twixt this life and a blessed eternity, and close forever those tired eyelids in the last long sleep of death.

For these noble duties and labors you have to-day consecrated yourselves, and after years in its service it is the hope of your teachers and your training school and hospital that it may be said of you: "Well done, thou good and faithful servant; thou hast been faithful over few things, I will make thee ruler over many things; enter thou into the joy of thy Lord."—Buffalo Med. Jour.

493 Delaware Avenue.

BROKE IN THE WAR; HOW THE WOUNDED JAPANESE ARE CARED FOR.

By J. Gordon Smith.

Correspondent for the London Morning Post with General Oku's army
(Canada Lancet.)

On a dull-grey morning I stood before Shinbashi station and watched the wounded arriving in Tokio; also guncarriages, limbers, horses and other trophies of war. There was more interest displayed by the throng which jostled me about the trophies than the wounded. The governmental practice is to send each batch of broken men to the divisional headquarters. These, whom I saw, were two officers and three hundred and forty-one men of the Imperial Guards of Tokio. About three months ago these men were entrained at night and went away without flare of trumpet, without any demonstration, steaming away under cover of darkness to land at night by the light of hundreds of torches on Korea's shores. Now they have returned with equal lack of demonstration.

Their home-coming was a sad sight. Under a leaden sky, on a dull, grey, depressing day they came from the train quietly and with no more show than if they had been a party of farm laborers returning from the rice fields south of the city. A great crowd was at the station but there was no welcoming shout. All was done in the most dispassionate business-like way. The majority walked more or less briskly from the platform carrying their goods packed in blankets and in haversacks slung from their shoulders; the greater number

were smoking cigarettes. Some were limping, their hands on the shoulders of others. A comparative few were carried on stretchers. Hundreds of 'kurumaya' with their little two-wheeled 'jinrikishkas' (literally translated, 'man-power cars') were standing in lines before the porch of the railway terminus, and, one by one, they were called by an officer of the medical corps to have a returned soldier seated in their little passenger carts. From the goods platform some Russian gun-carriages, three big horses—seeming large in comparison with the small Japanese ponies—some gun-limbers and ammunition wagons, and other trophies of the battle of the Yalu, were dragged out. The line of 'jinrikishkas' fell in behind.

It was a procession of strange contrasts. The silent people by the roadside saw the spoils of war they prized so much—the Japanese are very fond of the display of trophies such as these—and they were pleased. The gun-carriages passed; the limbers rolled by. Behind were coolies with mushroomlike hats and blue blouses, jogging on with the wounded. The red crosses on their white canvas kimonas and hats, such as those of pastry-cooks, were not needed to manifest the other side of war—the seamy side. One after another the broken soldiers were trundled past the onlookers, many bare-headed, many with white hospital cap worn over their yellow braided regimental cap, the hospital kimona over their foreign cut uniforms; all with crimson blankets slung from their left shoulders, in striking contrast with the white garments. Some had their heads bandaged, others had arms or legs bound in lint. The brown faces all had a pallor; they were a pitiable sight.

The procession was a long one, stretched out over a mile. Hundreds stood on the streets, not crowding in any place other than at the station, but in an almost continual line on each side of the roadways, each person absolutely silent. The soldiers themselves seemed to take little interest in their surroundings, looking at the landmarks about them with indifference. The sentinels at the gates of the Russian legation; the officials at the windows of the War and Naval Departmental buildings,—all else they saw on the way, had, seemingly, no interest to them. The old fellow with great smoked glasses giving him the appearance of a sage, who paid the 'kurumayas' at the hill-top, giving each coolie a ten sen piece and two sens—which allotment by the War Department for the transport of the sick and wounded were arranged in little piles on a big tray; the War Minister who drove past, his uniform glittering, in his carriage from the General Staff office, the 'gogai-runners' rushing by the little carts clanging their bells and shouting the name of the newspaper whose extras they sold; none of these things had, as far as one could see, any interest to the wounded man. They were impassive.

The Eyu Hospital of the medical corps stands on the brow of a hill, not a stone's throw from the General Staff office, where the generals were sitting at a board of strategy, devising new battles that would make more wounded even as the 'jinrikishkas' were rolled into the yard. Across the roadway from the ponderous gate which swings from two great beams joined by an equally massive beam overhead, is the moat, beyond is the old stone wall of the feudal days, with its overhanging trees hiding the palace buildings. The Tenshi Sama, for whom the men who had been injured in battle had gone to fight, and were eager to fight again, lived beyond that wall.

The hospital is a one-storied structure, square as a box other than for the wide porch, the curved roof of which, with a sweep, tiling, carvings and scrolled panels as pretty as those of a temple, gives the building a picturesque effect. Without this porch with its central panel of a sixteen-leaved chrysanthemum—the crest of the Tenshi Sama—the building would be a barren looking barn; with it the place is picturesque and pleasing. On the afternoon of that grey day when the several unfortunates broke in the war were squatted on the stones and grassy banks of the drive-ways as a spectacled doctor read the roll, the picturesqueness of the place was increased. The wounded squatting about added much to the effect.

All were kept sitting before the hospital entrance for nearly two hours. Everything was done with a system that was remarkably complete, often too complete, for regulations are sometimes carried to an absurd limit. The soldiers had all been landed at the hospital entrance and the doctor was calling the roll while assistants booked the names, when carts came with further supplies of hospital clothes. "Rikishkas" arrived with more doctors, and then came carts, drawn by horses and oxen, bringing heaped loads of wooden bunks, the peculiar box-like sleeping places of the Japanese soldiers in garrison. Three hundred and forty-one beds were moved into the almost bare rooms of the hospital by nightfall, and meanwhile the sick and wounded sat outside conversing with each other and smoking cigarettes, exhibiting bullets from Russian rifles and telling and retelling the story of the battles for the benefit of the men of the medical staff—and telling also of the disappointment each man felt at not being allowed to remain at the front. Some spoke emphatically of wrong done them in ordering their return. They were aggrieved for they felt that they were still fit to fight. Those who had practically recovered during the voyage home in the hospital ship had petitioned to be permitted to return even when en route home; all longed to be back.

I will long remember the scene, it was so very impressive. There was so much to be seen in the faces of the men who sat there, expres-

sions of indifference, of fatigue, of hope, of sorrow—all the emotions were there displayed, but held well in check, for a Japanese will ever mask sorrow with gladness if others watch. This is the way with all. I saw a mother and brother greet a wounded soldier amidst the throng who sat before the hospital. His hand was bandaged, his arm swollen, and his face was as pallid as a brown complexion can show pallor. Yet he smiled, his white teeth showing. There were no tears in his eyes, and no outburst of joy, no emotional display of any kind marked the coming of those he loved. The old woman, with a well-worn grey kimono bound close about her, shuffled over the pebbles with her high "geta," and her other son, the carpenter—the tradesman has a mark of his guild shown by the great ideographs monogrammed on the back of his coat—walked behind her. Neither displayed any feelings; the other soldiers were sitting by and it is not in public that the emotions are to be displayed. The soldier must not be shamed before his fellows. The calm exterior must mask the feelings, no matter what one does behind the paper-screened walls of the home. So the soldier bent his back, bowing ceremoniously, and the mother and brother bowed equally low and with equal form. They spoke in polite commonplace words as they greeted each other and, bowing again, separated. Imagine, if possible, an Anglo-Saxon mother receiving a wounded son without even a hand clasp. Yet that is the Japanese custom. Many were received by friends and relations, as I watched, with lack of emotional display. It is this seemingly restrained manner which the Japanese adopt in public, when whatever one feels, the indications of the feelings must be suppressed, that has given the foreign observer the impression that the Japanese are undemonstrative in their affections; that they lack emotion. But this is not so. In public the Japanese is undemonstrative. One would never think of showing any affection in public; that is for the home. And so, all who come to visit the wounded—people came and went until dusk—were received with ceremony. Meanwhile, the doctor who stood behind the table, placed on the steps at the entrance and heaped high with books and cards—there was a card for each man—called the soldiers one by one, and with a parting bow and hurriedly spoken "Sayonara," each man hurried into the building. There, the pharmacutists were busy distributing the medicines the doctors prescribed. It was nightfall before all were housed, and, as one of the dispensers informed me, it was morning before the work of attending to the reception of the men was completed. The doctors did not even have time to prepare afternoon tea for the volunteer nurses who had come from England and America; they did not have time to attend to the social requirements these ladies sought for many days. In time,

though they were able to send many of these men who came to them from the front, back again to fight for the Emperor—and for Japan.

I visited the hospitals of Tokio where the "men broke in the wars" were being treated, before I left for the front to join General Oku's army, and my experiences impressed me with the fact that the Japanese army surgeons are demonstrating to the satisfaction of medical men sent to Japan by various nations to study their methods of dealing with the sick and wounded, that more men recover from wounds when operations are not performed than otherwise. With the armies of Japan now in the field the surgeons are operating in very few cases; in no case do they operate until the second day, and then only in cases of extreme urgency. In the main, the wounds of those shot in the field are dressed antiseptically by the surgeons at the front and the dressings are not removed until such times as the soldiers are brought to a hospital where the conditions are perfect for the treatment of the wounded. Even then, there are few operations. The wounds are bathed with an antiseptic washing, and then, as an American army surgeon whom I met at Sekijuji, or Red Cross Hospital, said "they let the Lord do the rest—and He does it."

At both hospitals, the Biju Byoin, or military hospital, and the Sekijuji, or Red Cross Hospital, I saw how successful indeed was the Japanese method of treating the wounded. The high percentage of recoveries in comparison with the records of other armies in past campaigns is convincing that this policy of "laissez faire" adopted by the Japanese military doctors is accomplishing wonderful results. Both hospitals are single storied buildings with long narrow wards, windows and rows of beds on either side; the ventilation is exceedingly well arranged and everything is clean and sweet smelling. There are no bad odours. The percentage of recoveries was remarkable. I saw a large number of wounded who had perforating wounds in the chest going through the pleural cavity, yet not a case of pleurisy resulted. I also came in contact with some six cases of perforating wounds that passed through the abdominal cavity and out of the back, and, although the wounds were received not more than five or six weeks before, some of the men were sitting up in bed; two were walking about convalescent and complaining of the delay in permitting them to return to the front. True, the worst cases were probably not seen in the hospitals of Tokio. The men sent there, I understand, are selected from the cases brought to the southern depots by the hospital ships. But, nevertheless, the results secured by the surgeons are remarkable. The wounds I saw were nearly all clear perforations, and, unlike some bullet wounds I have seen, the orifice of exit was no larger nor less clear than the orifice of entrance. There

was no suppuration. I saw a bullet taken from a man's jaw and the jacket was perfect. The bullet had evidently been spent when it struck the soldier and had been stopped on striking the lower bone of the jaw. It differed little in size from the bullet used by the Japanese and was a smooth, pointed, compound metal-jacketed ball. The doctor who accompanied me offered the bullet to me, but the soldier was emphatic in his suggestions; he wanted the bullet as a souvenir and I gave it to him.

There were some remarkable cases. One soldier with whom I spoke, aided by an interpreter, had been struck by a bullet just under the left eye, where the orifice was plainly visible, and the bullet had passed through the sphenoid bone and perforated the tissue, coming out below the scapula of his right shoulder. His only suffering was from slight paralysis of his right arm, due to the fact that the bullet had broken one of the nerve tissues. And, although not more than forty-five days had elapsed, the soldier was able to tell of how he had been shot when charging with his comrade on the Russian position at Hohmatung. A more remarkable case seen at the military hospital was that of a man who had received a bullet in the forehead which had come out at the back of his head, both orifices being plainly shown, and he not only lived, but was sitting up in bed able to tell of his wound. He gives the credit of his recovery to a talisman in the shape of a samisen string which a geisha had tied about his waist. Another soldier received a bullet under his chin and left the top of his head; yet he was recovering. If the orifices made by the bullet were not so plain it would have been difficult to believe that possible. It seemingly is. The little spectacled doctor pointed out many instances in his text books; some of which are printed in English, some in German.

I met Surgeon-Major L. L. Seamen, of the U. S. Volunteers, at the Sekijuji-sha Byoin, and as we left to get into our 'jinrikishkas' he said to me, "After what I have seen, I would hesitate to operate on a single case at the front." The feature of the Japanese surgeon's work is that he leaves the wound alone; there are few operations, indeed, almost none at all. Of course there are some cases and such things where the knife is used, but it is used no more than is absolutely necessary. The "first aiding" dressing of the Japanese is very simple, and when it is placed on the wound by the surgeon at the front it is not touched again until a hospital is reached. The wounds are usually aseptic. Sometimes the wounds are jagged, the detachment of the jacket or introduction of foreign matter, cloth, button, etc., or the impingement or ricochet of the bullet being responsible for such wounds. These are in the minority, though, for the greater number

of wounds I saw in Japanese soldiers—and I saw hundreds in the field—had very minute orifices, those of entrance and exit being hardly distinguishable from each other in appearance. The Japanese believe it is far better to bandage a wound properly and avoid infection than risk danger by an operation under such conditions as prevail in the field. The Japanese are ever apt pupils and they are following well the examples set by Lister and Pasteur, to whom military surgery owes its greatest debt, and the Mikado's surgeons hold that the soldier who falls on the battlefield from the effect of a ball passing through any vital part of his anatomy and who has a "first aid" bandage promptly applied and is then transported to a general hospital where the Rontgen ray and the principles of asepsis and antisepsis can be utilized, has a far greater chance of recovery than when his wounds are treated on the field. In the war between the United States and Spain, the United States forces had 95.1 per cent. recoveries, while 4.9 per cent. died as a result of following these conservative methods. The Japanese have even better results.

While with General Oku in Manchuria I saw much of the work of the Japanese surgeons. They have much to do in keeping the armies under their charge up to the highest standard of health, so that in the emergency of battle the soldiers may be fitted to do their duty. The surgeons are also sanitary engineers, and they select the sites for camps, arrange camp drainage, locate latrines, and inspect all water supplies. It is the rule of the Japanese armies in the field to send a corps of medical experts in advance of the army, and, before the army pitches camp, every water supply in vicinity, every well, has been chemically analyzed. Placards are placed at all places where there is water. Some of the placards read "This water is good," others, "This water is bad" and still others, "This water should not be used unless it is boiled for half an hour." These precautions and the good ration in use prevents intestinal troubles and there are few cases of intestinal affections.

While I am on the subject of hospitals, a few words regarding the Japanese Red Cross Society might not be without interest. The Red Cross Society in Japan is an outcome of the Hakuaisha (Society of Benevolence) founded during the Satsums rebellion, the great civil war of 1877. At the close of the rebellion, the society was constituted a permanent organization, and, when Japan recognized the Geneva Convention, the Society of Benevolence procured a connection with the international committee at Geneva and was merged into the Red Cross Society of Japan. Now the society has over 800,000 members. An Imperial Prince is the honorary president and a Princess of the Blood, head of the ladies' committee. H. I. M. the Empress is a con-

stant visitor and patron of the hospitals of the society. Barons Ishiguro and Hashimoto, prominent Japanese medical men, are among the moving spirits of the society. The headquarters is in the capital, and consists of a number of buildings for central offices and storerooms. One room, elegantly furnished, is set apart for the use of the Empress or Emperor, and in this room are excellent full length oil paintings of their majesties. The society's hospital, the Sekijuji-sha Byoin, situated in Shibuya suburb, has 230 beds ordinarily, but more have been put in to accommodate the wounded that have arrived there. The Empress, who is a frequent visitor, has a room set apart for her at the hospital. The nurses, all gowned in white with an odd, high-crowned cap, number two hundred and sixty in all. The storerooms are large warehouse buildings, each laden with an enormous reserve supply of hospital stores, stacks of lanterns, canteens, blankets litters, trains of ambulance, cots, dressing material, etc. The society is the richest in the world. Within two days it can load a hospital ship or a hospital train, in readiness for the front. There is not the slightest confusion, the system being excellent. The nurses are all under military control. Two hospital ships are owned by the Society, the Kakuai Maru and Kosai Maru. In peace time they are leased to the Nippon Yusen Kaisha as passenger vessels. Now they are engaged in carrying the sick and wounded back to Japan from the front.

DIAGNOSIS OF SMALLPOX.

The confusing and conflicting opinions which prevail among physicians in the differentiation of smallpox and varicella are due to the variety of forms in which both of these diseases express themselves.

We are too apt to overlook the fact that smallpox and chicken-pox, like other diseases, are liable to present typical and atypical forms. This is most apt to occur when they coincidentally invade the same field and commingle their operations. Each disease now assumes to a certain extent the livery of the other, which, in a measure, changes the characteristics of both, and often renders identification difficult. Divergent opinions will continue to confuse the medical mind until the causes of smallpox and varicella are definitely ascertained. The most experienced observers are yet divided on the question of relationship between these diseases. American authorities are inclined to ascribe them to separate and distinct forms of virus, while many English and German writers recognize varicella as a modified form of variola. Erasmus Wilson, Hebra, Kaposi and Kassowitz have adopted the latter theory, and their opinions are entitled to great weight; but the fact that chicken-pox often prevails where there is not a single case of smallpox to be found, and presents an entirely dif-

ferent history, affecting mostly children, while smallpox finds its most favorable soil for proliferation in the adult, weakens the position they have taken. It is possible their opinions have been formed from their observation of varicella as it develops in connection with smallpox. Here it assumes some of the outward forms of smallpox, but these forms do not mature. They do not produce the grave symptoms of smallpox. They complete their work in from eight to fourteen days, while smallpox requires four weeks or more. Chicken-pox differs also from varioloid in many respects. Varioloid passes through all the stages of variola, but they are milder in type and shorter in duration. Varicella runs its course, as above stated, in from one to two weeks; varioloid requires from three to four weeks, and variola from four to five weeks. The constancy of their separate histories would seem to bar a unity of origin in variola and varicella. We are too apt to base our opinion of chicken-pox on the common vesicular form in which it expresses itself, but this form is only constant when chicken-pox operates independently of smallpox. When it follows in the wake of smallpox, the initial lesion assumes the cone form and is described by some authorities as "*varicella coniformis*." It is this borrowed element of chicken-pox, with which we are not familiar, that often leads us to confound it with smallpox. If we bear this in mind we will have less trouble in distinguishing one from the other.

While it is difficult to recognize smallpox before the eruption appears, the following symptoms will lead us to prepare for its advent: A severe chill, persistent vomiting, pain in the loins of a marked character, and high fever. The appearance, in about three days after these symptoms have developed, of papules on the forehead, face, hands and wrists gradually extending to other parts of the body, which inside of twenty-four hours are converted into umbilicated vesicles and later pass into pustules, will leave no doubt on the mind concerning the nature of the disease. In connection with these manifestations, if the fever has subsided after the appearance of the papular eruption and reappeared on the development of the pustular stage, our evidence of the disease is complete. It is readily distinguished from measles, scarlatina and syphilis; and we have only to bear in mind its different degrees of virulence, due to the potency of the virus and the sanitary environment of the patient, to differentiate it from varicella in all of its various forms.—American Journal of Dermatology.

Those of the medical profession who, like myself, have been in the harness for two score years or more, can look back to the primitive methods and remedies used by us in our earlier days of practice, and then note the advantages we enjoy today in the way of modern ther-

apeutic agents, and truthfully say that the advancement in the science of therapeutics and pharmaceuticals has been truly wonderful.

While it is true that we employ practically the same remedies as in the days gone by, or the active principles of the same drugs, yet thanks to the pharmaceutical chemist we are now enabled to prescribe them in a more agreeable form with all the inert matter eliminated and the desired constituent whose physiological action we wish to obtain remaining, and in the majority of preparations where that particular principle would be unpleasant to the palate, it is skillfully combined with aromatics, etc., that do not detract from its therapeutic value yet render it agreeable to take.

As an illustration I call your attention to a remedy that nodoubt the majority of us have used in treating tuberculosis, phthisis, scrofula, chronic pectoral complaints, and all wasting diseases. I refer to cod liver oil. From my experience and observation I think it has been used with uniform success in those cases wherein the use of a remedy of its nature was indicated. The only objection to its use that has ever been advanced to my knowledge, was the fact that many sensitive stomachs could not tolerate it on account of the disagreeable taste and smell; but now, thanks to the advancement in therapeutics, those disagreeable features have been eliminated, and we now have in Hagee's cordial of cod liver oil compound, a preparation containing all the active principles of cod liver oil, yet so skillfully combined with aromatics, etc., that the most sensitive and delicate stomach will not rebel at its administration; and thus we are enabled to use this sovereign remedy wherever its use is indicated. I have had some excellent results from its administration in cases of brain exhaustion and nervous debility, while in chronic pectoral complaints, and wasting diseases, and wherever an alterative and reconstructive tonic was needed, the above combination was my chief anchor.

Kansas City, Mo.

B. B. Ralph, M. D.

Physicians who prescribe Damiana have not read Dr. J. W. Lloyd's article published in many medical journals.

Resume':

"Damiana is a Mexican shrub. It was introduced to American medicine under a misunderstanding of its nature. It is not a medicine, but yielding to hot water a pleasant tea-like beverage, used by the poorer classes exclusively, innocent of the attributes under which it has been forced to masquerade."

In *Pil Orientalis* (Thompson)—see advertisement—you have a reliable Aphrodisiac, indicated in most cases of impotency and sexual weakness.

Immune Tablet Co.

Washington, D. C., Jan. 23, 1906,

THE ETIOLOGY, PROGNOSIS, AND TREATMENT OF GENERAL PARESIS.

Joseph Collins illustrates his paper by observations made on fifty private and fifty hospital cases of general paresis. The disease is due to syphilization and civilization, and it is with the first of these that physicians have to do. Important factors in the prophylaxis are the education of young men to premarital continence, and the thorough treatment of syphilis when it occurs. If general paresis can be detected in what Dana has called the preparitic stage, there is a chance of arresting it. The type of the disease that is least influenced by any kind of treatment is that form that begins insidiously, in which there is no symptom that stands out conspicuously to attract attention, and in which the patient often keeps to his occupation until a comparatively advanced stage of the disease; and the prognosis is worse in the young. The author details the encouraging results he has obtained in apparently arresting the disease in three cases of general paresis by intensive mercurialization, but he states that this plan has a chance of success only if the diagnosis is made very early. He therefore urges that general practitioners endeavor to make the diagnosis early. To this effect the diagnosis of neurasthenia should never be made by the general practitioner until after a routine physical examination has been made of the patient. Such examination will be productive of good in two directions; in the first place the diagnosis of neurasthenia will be made much less often, and in the second place general paresis will occasionally be recognized in its incipency. The slightest manifestation of loss of the pupillary light phenomenon, premonitional display of labial and facial tremor, unattributable lingual tremor, disorder of the tendon phenomenon, particularly of the lower extremities, occurring in a patient who has some one, any, or all of the symptoms of neurasthenia, should be immediately put in the category of suspected cases of general paresis, and if the suspicion is a strong one, should also be put upon vigorous antisiphilitic treatment.—Medical Record, January 27, 1906.

A UNIQUE REMEDY.

I find ANGIER'S PETROLEUM EMULSION of benefit, not alone in tuberculous cases where it occupies so large a place, but also in many cases of general debility, anaemic conditions and wherever the nutritive processes of the system are faulty it supplies nourishment and medicine at the same time.

I have a few cases of chronic bronchitis that find it the only thing to stand them along through the winter—these "winter coughs" that we do not expect to cure, especially in elderly people, but which we

must alleviate. Young or old, take this remedy with equal facility and assimilate it alike.

ANGIER'S is unique in its field, which is a large one.

A. P. Reed, M. D., Naples, Maine.

A FURTHER CONTRIBUTION TO THE TREATMENT OF TYPHOID BACILLURIA WITH UROTROPIN.

In concluding a paper on this subject in the Boston Medical and Surgical Journal of August 17, 1905, Easton says:

Although urotropin may, in very rare cases, cause uncomfortable symptoms, this does not invalidate the use of the drug.

Urotropin is of least value in cases where an active inflammation of the bladder has occurred.

But, as far as this series of observations goes, the moderate use of urotropin throughout the disease prevents cystitis.

Finally, the routine administration of the drug in all cases of typhoid fever would seem to be strongly indicated, for by such a course of treatment bladder complications are avoided, the urine made innocuous to those brought in contact with the patient, and it is possible to discharge patients who have been sick with typhoid fever in full belief that, as far as the urine is concerned, they will be harmless to the community.

THE CARE OF THE SICK OUTSIDE OF INSTITUTIONS.

Bertha A. Rosenfield's article deals with the treatment of the insane, who, she says, can most efficiently be cared for only outside of large institutions. In these it is impossible to give each patient the detailed attention that his needs, bodily and mental may require, and the general environment also is likely to be very unfavorable to recovery in many cases. She suggests the establishment of numerous homes for invalids, in some of which patients who are voluntarily under treatment will be received while others are intended for individuals requiring commitment. A beginning in this direction may be made by enlisting the aid of religious orders. In early cases of mental disease promptness in starting treatment may be very important, but is often impossible on account of the delays now attendant on securing commitment. It is a deplorable fact that there is no State provision for borderland cases in which stay in a big institution would be unsuitable, or for those among the poor who have recovered so far that removal from institutional care would be desirable but are not yet quite ready for discharge. This need is in some localities met by boarding out-patients in homes near the hospital and under official supervision.—Medical Record, January 27, 1906.

SOME OBSTETRICAL METHODS PRACTICED IN THE PHILIPPINES.

Wm. Duffield Bell says that the belief that the women of semicivilized races escape many of the pangs of childbirth is certainly erroneous regarding the Philippine natives. The life of the Filipino woman is comparatively short, due to her many pregnancies, much manual labor, insufficient food, and most of all to the crude, brutal, and ignorant practices employed as obstetric aids. The two chief procedures used to facilitate expulsion of the fetus consist first, in a stout band of cloth passed about the woman's abdomen and pulled tight by four persons, who are seated, two on each side of the patient, with their feet against her body, and second, in a plank six or eight feet long by a foot wide, which is placed across the woman's abdomen while another person, mounted on the plank, rises on his toes and lets the heels descend forcibly. The birth of the child is followed by the expulsion of the placenta by the above means, and, should the process be delayed, forcible traction on the umbilical cord is made to such an extent as to tear away portions of the placenta, and often large sections of this body are left to find their way from the uterine cavity of their own accord. Weeks and even months later the results of such practice are noticed in the septic conditions which would naturally follow retention of the membranes. The author gives some statistics showing the frequency of complications attending or following this crude midwifery, and then describes a case of imperforate hymen in a young girl. On account of the tumor caused by the accumulated blood she was supposed to be pregnant and was subjected to both the cloth and the plank treatment. She was then brought to the author, who incised the occluding membrane and liberated two quarts and four ounces of thick, offensive menstrual blood.—Medical Record, January 27, 1906.

FRONTAL SINUSITIS.

Thomson reports two fatal cases of frontal sinusitis, from which he draws the following conclusions: 1. In cases of multisinusitis it is well to drain the maxillary cavity some time before the frontal is operated on. Both cavities may be operated on at the same time; but if only one sinus is operated on at a time it should be the frontal sinus, the lower being drained until it can be opened. 2. In spite of free opening of the frontal sinus, the establishment of a large communication with the nose, and the avoidance of closure of the external wound a slow infection of the bone may take place leading ultimately to infection of the meninges. This may even be started in suppurating cavities on the opposite side to the one operated on. 3. The local condition of the wound, as well as the pulse, temperature, and feelings

of the patient may fail to indicate the onset of mischief. After one to three weeks this is revealed by headache, pain, tenderness, and puffy swelling on the forehead or around the eyes. 4. When septic osteomyelitis has started the most vigorous measures may fail to arrest it. It may last one and a half years before terminating fatally. 5. The chief danger appears to lie in the ethmoid labyrinth, owing to its anatomical irregularities and to the difficulty of treating them satisfactorily. 6. Up to the present the operation which best meets these difficulties is that of Killian. In many cases a preliminary intranasal operation on the ethmoid is advantageous.—*Lancet*, August, '05.

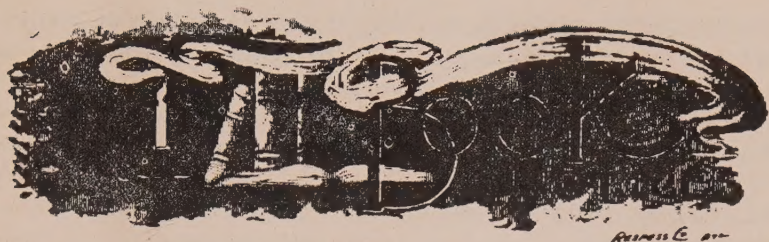
A FEW MORE WORDS CONCERNING MICE AND PNEUMONIA.

E. Palier says that his experiments lead him to believe that the microbe causing pneumonia is very polymorphous. A similar microbe was found in the mouths of all healthy individuals examined, and the microbes which were found in healthy individuals or in those suffering from pneumonia were not virulent enough to cause such a disease when injected into animals like the rat, which are not very susceptible to them. On the other hand, these microbes acquired a great virulence when they passed through a susceptible animal, like the house mouse. Owing to these reasons the writer holds that the most suitable name for the bacteria in question would be diplo-lanceobacilli-cocci, or for the sake of brevity, d. l. b. c., instead of pneumococci. He then reviews the various theories that have been suggested to explain the acquisition of virulence by these organisms, and concludes that it is owing to passage through the bodies of house mice. He has discovered the d. l. b. c. in the bodies of mice that have been found dead and believes that the virulent germs from the feces or decomposing bodies of these animals serve as the source of the disease in man. As mice are most common in houses during the months of December, January, February, and March, the seasonal distribution of pneumonia is also accounted for by this theory.—*Medical Record*, January 27, 1906.

GRIPPE.

An eliminant in the treatment of grippe is self-evident, for the sooner the germ of the disease is expelled, the more rapid the recovery and the less likelihood of any sequelae.

Tongaline presents an ideal remedial agent in grippe because it relieves the pain, reduces the fever, eliminates the poisons and stimulates recuperation.



A TEXT-BOOK ON MODERN MATERIA MEDICA AND THERAPEUTICS. By A. A. Stevens, A. M., M. D., Lecturer on Physical Diagnosis, University of Pennsylvania; Professor of Pathology, Woman's Medical College of Philadelphia. Fourth Edition, Revised. Octavo of 670 pages. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, \$3.50 net.

The new fourth edition of Dr. Stevens' excellent work on practical therapeutics appears at a most opportune time, close upon the issuance of the Eighth Decennial Revision of the Pharmacopeia to which it has been adapted. Dr. Stevens, by his extensive teaching experience, has acquired a clear, concise diction that adds greatly to his work's pre-eminence. New articles have been added on Scopolamin, Ethyl Chlorid, Theocin, Veronal, and Radium, besides much new matter to the section on Radiotherapy. The numerous changes in name or strength of various drugs and preparations, as called for by the new Pharmacopeia, have also been made. In fact, it is somewhat difficult to speak of Dr. Stevens' Therapeutics without resorting to the frequent use of superlatives, for of all the good works on this most important of subjects, this book before us is undoubtedly the very best.

A TREATISE ON DIAGNOSTIC METHODS OF EXAMINATION.

By Prof. Dr. H. Sahli, of Bern. Edited with additions, by Francis P. Kinnicutt, M. D., Professor of Clinical Medicine, Columbia University, N. Y.; and Nath'l Bowditch Potter, M. D., Visiting Physician to the City Hospital and to the French Hospital; and Consulting Physician to the Manhattan State Hospital, N. Y., Philadelphia and London: W. B. Saunders & Company, 1905. Octavo of 1008 pages, profusely illustrated. Cloth, \$6.50 net; Half Morocco, \$7.50 net.

We have been anxiously awaiting the publication of Dr. Sahli's great work in English. Its immediate success in Germany will certainly be repeated in this country, and the English-speaking profes-

sion owe to Messrs. W. B. Saunders & Company a debt of gratitude for their enterprise. Not only does the distinguished professor exhaustively consider all methods of examination for the purpose of diagnosis, but the explanations of clinical phenomena are given and discussed from physiologic as well as pathologic points of view, and with a thoroughness never before attempted in any clinical work. The examinations of the stomach, sputum, feces, urine, and blood are exhaustively treated. There is an article from the pen of Dr. Theodore C. Janeway giving a brief review of the investigations of American and English observers upon the value of the clinical estimation of blood-pressure, with a description of some newly devised instruments. Some of the new features in the chapter on urine examination are: Seliwanow's reaction for levulose, Bial's test for pentoses, and quantitative determination of urochrome after Klemperer. Osmotic pressure and cryoscopy of the urine are also discussed at length, and a description is given of Liebermann and Posner's method of staining urinary pigments. In the chemical examination much attention is directed to describing methods; and this is done so exactly that it is possible for the clinician to work according to these directions. The nervous system has been very elaborately detailed, giving unusual space to electrical examination. Indeed, the American edition of this great work contains all the material of the new fourth German edition, with which it simultaneously appeared. Many new illustrations have been added by the editors. The work is indispensable to the practitioner.

ESSENTIALS OF MATERIA MEDICA, THERAPEUTICS, AND PRESCRIPTION WRITING. By Henry Morris, M. D., College of Physicians, Philadelphia. Seventh Edition, Thoroughly Revised. By W. A. Bastedo, Ph. G., M. D. Instructor in Materia Medica and Pharmacology at the Columbia University (College of Physicians and Surgeons), New York City. 12mo, 300 pages. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, \$1.00 net.

The student cannot find a better or more practical work on Materia Medica, Therapeutics, and Prescription Writing than this little essentials from the press of W. B. Saunders and Company. But then, this work is no exception in this respect to all the other numbers of this excellent series of compends. Dr. Bastedo, in revising the book for this seventh edition, has brought it in accord with the new (1905) Pharmacopeia, introducing all the new remedies and carefully indicating their therapeutic doses and uses. For a work of three hundred pages it contains a mine of information so presented as to be easily grasped. We give it our unqualified endorsement.

A TEXT-BOOK OF MEDICAL CHEMISTRY AND TOXICOLOGY.

By James W. Holland, M. D., Professor of Medical Chemistry and Toxicology, and Dean, Jefferson Medical College, Philadelphia. Octavo volume of 600 pages, fully illustrated, including 8 plates in colors. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, \$3.00 net.

Dr. Holland possesses the faculty of making even the most difficult and complicated chemical theories and formulae easy and clear. This is probably due to his thirty-five years of practical experience in teaching chemistry and medicine. Recognizing that to understand physiological chemistry students must first be informed upon points not referred to in most medical text-books, the author has included in his work the latest views of equilibrium of equations, mass-action, cryoscopy, osmotic pressure, dissociation of salts into ions, the effects of ionization upon electric conductivity, and the relationship between purin bodies, uric acid, and urea. Chemical substances he has treated from the standpoint of the medical student and physician, giving much more space to Toxicology than is given in any other text-book on chemistry. The chapters on the clinical chemistry of milk, gastric contents, and the urine, and that on water supply and filtration are full of practical information. Dr. Holland's work will undoubtedly be gladly received by the profession, presenting as it does the mature experience of a practical teacher.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. By James

M. Anders, M. D., Ph. D. LL. D., Professor of Medicine and of Clinical Medicine at the Medico Chirurgical College, Philadelphia. Seventh edition, revised and enlarged. Octavo of 1297 pages, fully illustrated. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, \$5.50 net; Sheep or Half Morocco, \$6.50 net.

A sale of over 22,000 copies and the attainment of a seventh edition seems sufficient recommendation for any book; in fact, Anders' Practice does not now need any recommendation—it is too well known. As in the former editions, particular attention is bestowed upon inductive diagnosis, differential diagnosis, and treatment. Regarding differential diagnosis, we notice with much satisfaction that the many diagnostic tables of simulating diseases have been retained. The clinical value of these tabulated points of distinction is beyond cavil. Numerous new subjects have been introduced, among which are: Rocky Mountain Spotted Fever, Examination of Patients for Diagnosis of Diseases of the Stomach, Splanchnoptosis, Cammidge's Test for Glyceroase in the Urine, and Myasthenia Gravis. Certain other individual affections have been entirely rewritten and important additions have

been made to the diseases which prevail principally in tropical and subtropical regions. The seventh edition of Dr. Anders' Practice maintains the reputation of the work as the best practice before the profession today.

GALL-STONES AND THEIR SURGICAL TREATMENT. By B. G. A. Moynihan, M. S. (London), F. R. C. S., Senior Assistant to Leeds General Infirmary, Leeds, England. Second edition, revised and enlarged. Octavo of 458 pages, beautifully illustrated. Philadelphia and London. [W. B. Saunders & Company, 1905. Cloth, \$5.00 net; Half Morocco, \$6.00 net.

The first edition of Mr. Moynihan's work on gall-stones was completely exhausted in eight months. Mr. Moynihan, by his masterly presentation of operative technic and clear, logical discussion of indications and contraindications, has won an enviable place in contemporary abdominal surgery. In this edition, increased in size by some seventy pages, many additional case records have been incorporated and a number of new illustrations added. We note also the addition of a very valuable chapter—Congenital Abnormalities of the Gall-Bladder and Bile-Ducts. It is evident that the whole text has undergone a careful revision and all recent work along the line of gall-stone surgery included. Mr. Moynihan's book still holds first place in its field. The illustrations are very beautiful, especially the nine colored plates.

THE TREATMENT OF NASAL CATARRH.

By John A. Hale, M. D., Alto Pass, Ill.

For years I used various remedies and met with varying success, until tiring of one remedy after another I relied solely on Potassium Permanganate in weak solutions as a nasal douche, but a review of some points in this paper will show why I always sought for something else. Glyco-Thymoline has usurped the place of the permanganate solution in my armamentarium, and after sufficient trial established faith, implicit faith, in its specific thereapeusis for this condition. A knowledge of its essential constituents and their therapeutic action only tends to strengthen a belief in its specificity. Caution is necessary in the selection and use of remedies, but a fair trial has proven no untoward inconvenience emanating from the use of this remedy. Meanwhile the therapeutic results are gratifying and the good effects of Glyco-Thymoline can be easily verified by a trial, when conclusion will be the result of practical truths only.